

Medical Services

Patient Administration

**Headquarters
Department of the Army
Washington, DC
12 March 2001**

UNCLASSIFIED

SUMMARY of CHANGE

AR 40-400

Patient Administration

This revision--

- o Clarifies identification procedures using the Defense Enrollment Eligibility Reporting System (para 2-2).
- o Discusses primary care management (para 2-4).
- o Provides non-medical attendant travel guidance (para 2-6).
- o Clarifies coverage of maternity care for active duty members (para 2-8).
- o Requires that surgical intervention for a Reserve Component soldier's preexisting condition will not be performed unless it was incurred or aggravated in the line of duty (para 2-9).
- o Updates consent policy for a nonmilitary patient (para 2-12).
- o Prescribes the following forms formerly prescribed by AR 40-2: DA Form 3981 (Transfer of Patient) (para 2-13); DA Form 4160 (Patient's Personal Effects and Clothing Record) (para 4-4); DD Form 599 (Patient's Effect Storage Tag) (para 4-5); DA Form 4029 (Patient Clearance Record) (para 4-6a(3)); DA Form 3821 (Report of Administrative Officer of the Day) (para 6-2a); DA Form 2984 (Very Seriously Ill/Seriously Ill/Special Category Patient Report) (para 6-2b(1)); DA Form 3894 (Hospital Report of Death) (para 6-4a); DA Form 3910 (Death Tag) (para 6-4b); DA Form 3696 (Patient's Deposit Record) (para 12-4a); DA Form 4128 (Patients' Trust Fund Journal) (para 12-4a); DA Form 3983 (Patients' Trust Fund--Authorization for Deposit or Withdrawal of Funds and Valuables) (para 12-7); and DA Form 4665 (Patients' Trust Fund--Daily Summary Record) (para 12-7).
- o Addresses care beyond a military treatment facility's capability (para 2-14).
- o Adds further information required for requests for authority to engage care (para 2-14).
- o Updates Department of Defense abortion policy in military treatment facilities (para 2-18).
- o Clarifies when applicants for enlistment or reenlistment may be hospitalized (para 3-6).
- o Updates dental care entitlements of family members (para 3-11).
- o Clarifies eligibility for nonappropriated fund Federal employees (para 3-15).

- o Entitles Department of Defense employees to free care if given in occupational health or Office of Workers' Compensation Programs (paras 3-15 and 3-24).
- o Implements Department of Defense Instruction 6015.23, Delivery of Health Care at Military Treatment Facilities (MTFs) dated 9 December 1996 (para 3-21a.)
- o Prescribes the following forms formerly prescribed by AR 40-330: DD Form 7 (Report of Treatment Furnished Pay Patients: Hospitalization Furnished (Part A) (para 3-21b(3)); DD Form 7A (Report of Treatment Furnished Pay Patients: Outpatient Treatment Furnished (Part B) (para 3-24b(3)(b)); DA Form 3154 (MSA Invoice and Receipt) (para 11-7a); DA Form 3153 (Medical Service Account Patient Ledger Card) (para 11-9); DA Form 3155 (MSA Cash Record) (para 11-9); and DA Form 3929 (MSA--Accounts Receivable Register and Control Ledger) (para 11-9).
- o Clarifies Office of Workers' Compensation Program coverage in accident cases and during travel (para 3-24).
- o Provides a notification point of contact for hospitalized Public Health Service or National Oceanic and Atmospheric Administration officers (para 3-25).
- o Clarifies eligibility and charges of former officers of Public Health Service and National Oceanic and Atmospheric Administration and their newborn infants (para 3-25).
- o Redefines authority for Secretary of the Army designees and articulates eligibility for nonactive duty chaplains at the United States Military Academy (para 3-50).
- o Adds a new eligibility paragraph addressing family members of certain sentenced, discharged, or dismissed members (para 3-52).
- o Explains eligibility for volunteer subjects in approved Department of the Army research projects (para 3-56).
- o Adds a new paragraph addressing evaluation of suspected Service connected conditions and persons with extended medical benefits (para 3-61).
- o Explains eligibility of donors and recipients of organ transplants performed in military treatment facilities (para 3-63).
- o Adds a new paragraph addressing health benefits of unremarried former spouses (para 3-66).
- o Implements North Atlantic Treaty Organization (NATO) standardization agreements (STANAGs) 2061, 2101, 2132, and 3113; American, British, Canadian, and Australian (ABCA) Quadripartite Standardization Agreement (QSTAG) 470; and Standardization of Certain Aspects of Operations and Logistics (SOLOG) 74 (chaps 3 and 4).
- o Clarifies policy on patient absences from military hospital wards (para 4-1).

- o Rescinds eligibility for care of participants in Domestic Action Programs (formerly para 4-63).
- o Rescinds eligibility references to the Citizens Military Training Corps (formerly para 5-3).
- o Prescribes the following forms formerly prescribed by AR 40-3: DD Form 675 (Receipt for Records and Patients Property) (para 5-18a(6)(a)); DA Form 3947 (Medical Evaluation Board Proceedings) (para 7-8a); DA Form 4707 (Entrance Physical Standards Board (EPSBD) Proceedings) (para 7-11a); DA Form 4159 (Request for Medical Care in a Federal Medical Treatment Facility Outside Department of Defense) (para 9-5).
- o Allows telephonic notification of an active duty general officer hospitalization (para 6-3).
- o Adds a further address for copy of medical board proceedings pertaining to Medical Corps officers (para 7-13).
- o Explains the managed care benefit of the Uniformed Services Family Health Plan (para 9-8).
- o Adds a listing of Uniformed Services Family Health Plan locations (fig 9-1).
- o Clarifies how to acquire care for active duty personnel stationed in remote areas (para 10-6).
- o Includes Civilian Health and Medical Program of the Uniformed Services maximum allowable claims payment guidance (para 10-9).
- o Clarifies how to assess charges for outpatient care provided to reimbursable patients (para 11-14).
- o Authorizes payment by credit card for medical services account collections (para 11-16).
- o Prescribes DA Form 2631 (Medical Care--Third Party Liability Notification) formerly prescribed by AR 40-16 (para 13-1).
- o Incorporates the Third Party Collection Program (chap 14).

- o Clarifies charges for foreign nationals (app B).
- o Rescinds the use of DA Form 2789-R (Medical Summary Report-Section I (LRA)); DA Form 2789-1-R (Medical Summary Report-Section II (LRA)); DA Form 2789-2-R (Medical Summary Report-Section III (LRA)); DA Form 2789-3-R (Medical Summary Report-Section IV (LRA)); DA Form 2789-4-R (Medical Summary Report-Section V (LRA)); DA Form 3156 (Statement of MSA Accountable Patient Days and Reimbursements); DA Form 3158 (Statement of MSA Dining Hall Cash Receipts and Meals Served); DA Form 3586 (Report of Professional Officer of the Day); DA Form 3904 (Public Voucher for Medical Examination); DA Form 4167 (Ward Pass List); DA Form 4303 (Titling Card, Photo Fluorographic Film); DA Form 4375 (Patient's Interward Transfer); DA Form 4582-R (Inpatient Accounting System Admission Record (LRA)); DA Form 4593 (MSA Transaction Card); DA Form 4595-R (Inpatient Admission System For the Medical Summary Report); DA Form 5663-R (Confidential Affidavit of Financial Status); DA Form 5664-R (Promissory Note in Repayment of Preexisting Debt); RCS MED-16 (The Special Telegraphic Report of Selected Conditions); RCS MED-302 (Medical Summary Report System); and RCS MED-345 (Individual Patient Data System).

Effective 12 April 2001

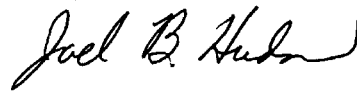
Medical Services

Patient Administration

By Order of the Secretary of the Army:

ERIC K. SHINSEKI
General, United States Army
Chief of Staff

Official:



JOEL B. HUDSON
Administrative Assistant to the
Secretary of the Army

History. This issue publishes a revision of this publication. Because the publication has been extensively revised, the changed portions have not been highlighted.

Summary. This consolidated regulation prescribes policies and mandated tasks governing the management and administration of patients. It includes DOD and statutory policies regarding medical care entitlements and managed care practices. It also implements North Atlantic Treaty

Organization and American, British, Canadian, and Australian approved standardization agreements.

Applicability. This regulation applies to the Active Army and Reserve Components. It also applies to medical department activities, medical centers, dental activities, and organizations for which the Army Medical Department is the executive agent. This publication is applicable during mobilization.

Proponent and exception authority. The proponent of this regulation is The Surgeon General. The proponent has the authority to approve exceptions to this regulation that are consistent with controlling law and regulation. Proponents may delegate this approval authority, in writing, to a division chief within the proponent agency in the rank of colonel or the civilian equivalent.

Army management control process. This regulation contains management control provisions and identifies key management controls that must be evaluated.

Supplementation. Supplementation of

this regulation and establishment of command and local forms are prohibited without prior approval from Headquarters, Department of the Army (OTSG) (DASG-HSZ), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

Suggested Improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to OTSG (DASG-HSZ), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

Distribution. This publication is available in electronic media only and is intended for command levels B, C, D and E for the Active Army, C, D, and E for Army National Guard of the United States, and B, C, D, and E for U.S. Army Reserve.

Contents (Listed by paragraph and page number)

Chapter 1

Introduction, *page 1*

Purpose • 1-1, *page 1*

References • 1-2, *page 1*

Explanation of abbreviations and terms • 1-3, *page 1*

Responsibilities • 1-4, *page 1*

Chapter 2

Patient Policies, *page 1*

Eligibility verification • 2-1, *page 1*

Identification procedures • 2-2, *page 1*

Priorities • 2-3, *page 1*

Primary care management • 2-4, *page 2*

*This regulation supersedes paragraphs 1-2, 1-3, 1-6, and chapters 2, 4, and 6 of AR 40-2, dated 3 March 1978; chapters 1, 3, 4, 5, 6, 7, 8, 13, 14, 15, 16, and all portions of chapter 2 except paragraphs 2-11 and 2-22 of AR 40-3, dated 15 February 1985; AR 40-16, dated 8 August 1974; chapter 5 of AR 40-330, dated 25 February 1988; and AR 40-400, dated 1 November 1983. It rescinds DA Forms 2789-R, 2789-1-R, 2789-2-R, 2789-3-R, 2789-4-R, 4582-R, and 4595-R, all dated September 1983; DA Form 4593 dated March 1977; DA Form 4375 dated July 1975; DA Form 4167 dated October 1973; DA Form 3904 dated August 1972; DA Form 4303 dated August 1974; DA Form 3586 dated April 1970; DA Form 3156 dated July 1978; DA Form 3158 dated July 1966; DA Forms 5663-R and 5664-R, both dated September 1987; and RCS MED-16, RCS MED-302, and RCS MED-345.

Contents—Continued

NATO STANAG/ABCA QSTAG/SOLOG agreements • 2–5, *page 2*
Commercial transportation or travel and nonmedical attendant travel • 2–6, *page 3*
Medical examinations for insurance purposes • 2–7, *page 3*
Maternity care for active duty members • 2–8, *page 3*
Remediable physical defects developed in the military service • 2–9, *page 3*
Hospitalization before the effective date of separation or retirement orders • 2–10, *page 4*
Statements of prolonged hospitalization • 2–11, *page 4*
Consent by a nonmilitary patient to medical care • 2–12, *page 4*
Patient transfers • 2–13, *page 5*
Care beyond an MTFs capability • 2–14, *page 6*
Admission of psychiatric patients • 2–15, *page 6*
Ancillary medical services • 2–16, *page 6*
Family planning services • 2–17, *page 6*
Abortions • 2–18, *page 6*
Cosmetic surgery • 2–19, *page 7*

Chapter 3

Persons Eligible for Care in Army MTFs and Care Authorized, *page 9*

Section I

Members of the Uniformed Services, page 9

Members of the Uniformed Services on active duty • 3–1, *page 9*

Members of the Uniformed Services Reserve Components • 3–2, *page 9*

Members of the Senior Reserve Officers' Training Corps of the Armed Forces • 3–3, *page 11*

Section II

Applicants, page 11

Designated applicants for enrollment in the Senior Reserve Officers' Training Program (except ROTC scholarship applicants) • 3–4, *page 11*

Applicants for cadetship at the Service academies and ROTC scholarship applicants • 3–5, *page 12*

Applicants for enlistment or reenlistment in the Armed Forces, including applicants for enlistment in the Reserve Components • 3–6, *page 12*

Applicants for appointment in the Regular Army and Reserve Components including members of the Reserve Components who apply for active duty • 3–7, *page 12*

Applicants who suffer injury or acute illness • 3–8, *page 12*

Section III

Retired Members of the Uniformed Services, page 12

Eligible retired members • 3–9, *page 12*

Periodic medical examinations • 3–10, *page 12*

Section IV

Family Members of the Uniformed Services, page 12

Care authorized family members • 3–11, *page 12*

Medical care not authorized family members • 3–12, *page 12*

Surviving dependents of Reserve members • 3–13, *page 13*

Section V

Federal Civilian Employees and Their Family Members, page 13

Federal civilian employees • 3–14, *page 13*

Occupational health services • 3–15, *page 13*

Federal civilian employees and their family members outside the United States and at remote installations in the United States • 3–16, *page 14*

Department of Interior civilian employees stationed in American Samoa and their family members • 3–17, *page 14*

Contents—Continued

Section VI

Foreign Nationals, page 14

Care provided in the United States • 3–18, *page 14*

Notification of hospitalization in the United States • 3–19, *page 15*

Care provided outside the United States • 3–20, *page 15*

Charges for and extent of care • 3–21, *page 16*

Section VII

Beneficiaries of Other Federal Agencies, page 17

General • 3–22, *page 17*

Beneficiaries of the Department of Veterans Affairs • 3–23, *page 17*

Beneficiaries of the Office of Workers' Compensation Programs • 3–24, *page 19*

Beneficiaries of the Public Health Service and National Oceanographic and Atmospheric Administration • 3–25, *page 21*

Selective Service registrants • 3–26, *page 21*

Beneficiaries of the Department of State and associated agencies • 3–27, *page 21*

Peace Corps personnel (volunteers, volunteer leaders, and employees), including Peace Corps applicants, and family members of volunteer leaders and employees • 3–28, *page 23*

Members of the U.S. Soldiers' and Airmen's Home • 3–29, *page 23*

Beneficiaries of the Department of Justice • 3–30, *page 23*

Beneficiaries of the Treasury Department • 3–31, *page 24*

Federal Aviation Administration air traffic control specialists • 3–32, *page 24*

Job Corps and other Congressionally mandated Volunteer Programs in Service to America and applicants • 3–33, *page 24*

Social Security beneficiaries • 3–34, *page 25*

Micronesian citizens • 3–35, *page 25*

American Samoan citizens • 3–36, *page 25*

Section VIII

Miscellaneous Categories of Eligible Persons, page 25

Secret Service protectees and protectors • 3–37, *page 25*

Persons in military custody and nonmilitary Federal prisoners • 3–38, *page 25*

Maternity care for former members of the Armed Forces • 3–39, *page 26*

Individuals whose military records are being considered for correction • 3–40, *page 26*

Seamen • 3–41, *page 26*

Red Cross personnel • 3–42, *page 27*

Civilian student employees • 3–43, *page 27*

Civilian employees of U.S. Government contractors and their family members outside the United States • 3–44, *page 27*

Medical examinations for civilian employees of DOD contractors • 3–45, *page 27*

Civilian participants in Army-sponsored activities • 3–46, *page 28*

Claimants whose claims are administered by Federal departments and claimants who are the proposed beneficiaries of private relief bills • 3–47, *page 28*

Persons who provide direct services to the U.S. Armed Forces outside the United States • 3–48, *page 28*

American nationals • 3–49, *page 28*

Designees of the Secretary of the Army • 3–50, *page 28*

Preadoptive children and court appointed wards • 3–51, *page 29*

Family members of certain members sentenced, discharged, or dismissed from the Uniformed Services • 3–52, *page 29*

Ineligible persons outside the United States • 3–53, *page 30*

Certain personnel evacuated from one area to another • 3–54, *page 30*

Civilians in emergency • 3–55, *page 30*

Volunteer subjects in approved Department of the Army research projects • 3–56, *page 30*

U.S. nationals in foreign penal institutions • 3–57, *page 30*

Domestic servants outside the United States • 3–58, *page 30*

Contents—Continued

U.S. contractor civilian employees stationed in American Samoa • 3–59, *page 30*
Civilians injured in alleged felonious assaults on Army installations • 3–60, *page 30*
Treatment of former military personnel • 3–61, *page 30*
Returned military prisoners of war and their family members • 3–62, *page 31*
Donors and recipients of organ transplants performed in MTFs • 3–63, *page 31*
Civilian faculty members of the Uniformed Services University of Health Sciences • 3–64, *page 31*
Civilians in a national or foreign disaster • 3–65, *page 31*
Unmarried former spouse • 3–66, *page 31*

Chapter 4

Management and Accountability of Hospitalized Patients, *page 34*

Patient control • 4–1, *page 34*
Patient identification • 4–2, *page 34*
Comfort items for patients • 4–3, *page 34*
Government property • 4–4, *page 34*
Personal effects • 4–5, *page 35*
Patient accountability and admission processes • 4–6, *page 35*
NATO STANAG 2132 and ABCA QSTAG 470 International Agreement requirements • 4–7, *page 36*

Chapter 5

Dispositioning Patients, *page 36*

General policies • 5–1, *page 36*
Responsibility for dispositions • 5–2, *page 37*
Types of disposition for Army members • 5–3, *page 37*
Recommendation for change of duty or station • 5–4, *page 38*
Return of Army military patients from overseas to CONUS for medical reasons • 5–5, *page 38*
Length of hospitalization for AD Army soldiers • 5–6, *page 38*
Use of subsisting out status • 5–7, *page 39*
Members on the temporary disability retired list • 5–8, *page 39*
Members of the RC and ROTC members • 5–9, *page 39*
U.S. Navy/Marines and U.S. Air Force military patients • 5–10, *page 40*
Domiciliary care • 5–11, *page 40*
Sick call • 5–12, *page 40*
Prisoner patients • 5–13, *page 40*
Psychiatric patients • 5–14, *page 41*
Psychiatric prisoner patients • 5–15, *page 41*
Notification of release of criminal Army members • 5–16, *page 41*
Final disposition procedures for military patients • 5–17, *page 42*
Military patients requiring continued hospitalization or nursing home care after separation • 5–18, *page 42*
Request for medical and/or dental records • 5–19, *page 44*
Patients of NATO nations • 5–20, *page 45*
Foreign military patients from non-NATO nations • 5–21, *page 45*
Types of disposition for nonmilitary patients • 5–22, *page 45*
Nonmilitary patients mentally ill in a foreign country • 5–23, *page 45*
Evacuation of military spouses from overseas areas to the United States • 5–24, *page 46*

Chapter 6

Patients in Special Circumstances, *page 47*

General • 6–1, *page 47*
Very seriously ill, seriously ill, SPECAT, (not SI) hospital care required, and (not SI) hospital care not required • 6–2, *page 47*
Hospitalization of special interest patients and enabling care policy • 6–3, *page 48*
Deceased persons • 6–4, *page 49*
Autopsy authority and consent • 6–5, *page 49*

Contents—Continued

Chapter 7

Military Personnel Physical Disability Processing, page 50

General • 7-1, *page 50*

Appointing authority • 7-2, *page 50*

Composition • 7-3, *page 50*

Medical board procedures for Medical Corps officers • 7-4, *page 50*

Use of medical evaluation boards • 7-5, *page 51*

Sanity boards • 7-6, *page 51*

Medical evaluation board proceedings • 7-7, *page 52*

Recording proceedings • 7-8, *page 52*

Preparation of DA Form 3947 • 7-9, *page 52*

Documentation for referral to a physical evaluation board • 7-10, *page 53*

Expedition discharge • 7-11, *page 53*

Medical evaluation board approving authority • 7-12, *page 55*

Distribution of medical evaluation board proceedings • 7-13, *page 55*

Interservice cooperation in medical evaluation board actions • 7-14, *page 55*

Triservice medical evaluation board coordination • 7-15, *page 55*

Options available to the Service reviewing authority • 7-16, *page 56*

Counseling members concerning medical board results • 7-17, *page 56*

Transmittal of medical evaluation board proceedings by Service reviewing authority to Service physical evaluation boards • 7-18, *page 56*

Processing actions related to physical evaluation boards • 7-19, *page 56*

VA Physician's Guide for Disability Evaluation Examinations and the VASRD • 7-20, *page 56*

Referrals • 7-21, *page 56*

Referral to the physical evaluation board liaison officer • 7-22, *page 57*

Records sent to a physical evaluation board • 7-23, *page 57*

Preparing medical evaluation board narrative summaries • 7-24, *page 57*

Chapter 8

Medical Holding Unit, page 59

General • 8-1, *page 59*

Notification of admission and discharge • 8-2, *page 59*

Attachment of AD Army personnel to a medical holding unit • 8-3, *page 59*

Assignment of AD Army personnel to a medical holding unit • 8-4, *page 59*

Individual records and clothing • 8-5, *page 60*

Return to duty of attached patients • 8-6, *page 60*

Disposition of assigned patients in CONUS • 8-7, *page 61*

Requests for assignment instructions • 8-8, *page 61*

Duty for assigned patients awaiting orders in CONUS • 8-9, *page 62*

Disposition of patients in overseas MTFs • 8-10, *page 62*

Separation of enlisted personnel assigned to medical holding units • 8-11, *page 62*

Disposition of Reserve Component personnel • 8-12, *page 62*

Performance of duty while in patient status • 8-13, *page 62*

Prolonged definitive medical care for AD military patients who are unlikely to return to duty • 8-14, *page 62*

Chapter 9

Administration of Patients in Non-Army MTFs, page 62

Care in Navy and Air Force MTFs • 9-1, *page 62*

General policies applying to care in Navy and Air Force MTFs • 9-2, *page 62*

Army administrative units at Navy and Air Force MTFs • 9-3, *page 63*

Care in Federal MTFs other than those of the Uniformed Services • 9-4, *page 63*

Authorization • 9-5, *page 63*

Use of Federal medical treatment facilities for supplementation • 9-6, *page 64*

Reimbursement to other Federal facilities • 9-7, *page 64*

Special consideration of Uniformed Services Family Health Plan beneficiaries • 9-8, *page 64*

Contents—Continued

Administration of patients treated at Federal MTFs other than the Uniformed Services and civilian facilities • 9–9, *page 64*

Chapter 10

Care From Civilian Sources, *page 65*

For whom authorized • 10–1, *page 65*

Qualifications of professional personnel engaged to furnish medical care • 10–2, *page 65*

Special considerations for AWOL members receiving civilian medical care • 10–3, *page 66*

Apprehended members of the Army who are confined or committed by civil authorities • 10–4, *page 66*

Approving authorities • 10–5, *page 66*

Authorization for civilian medical care • 10–6, *page 66*

Dental care in civilian facilities for active duty personnel • 10–7, *page 67*

Autopsies • 10–8, *page 67*

Rates of compensation • 10–9, *page 67*

Payment of civilian medical claims • 10–10, *page 67*

Medical records and reports • 10–11, *page 67*

Chapter 11

Medical Services Accounts, *page 67*

Policies • 11–1, *page 67*

Medical services accountable officer appointment • 11–2, *page 67*

Medical services accountable officer deputy appointment • 11–3, *page 67*

Assistant medical services accountable officers • 11–4, *page 68*

Emergency relief of the medical services accountable officer • 11–5, *page 68*

Transfer of medical services accounts accountability • 11–6, *page 68*

Medical services accountable officer discontinuance statement • 11–7, *page 68*

Change fund • 11–8, *page 68*

Automation • 11–9, *page 69*

Audit and review • 11–10, *page 69*

Physical loss of medical services accounts funds • 11–11, *page 69*

Reports • 11–12, *page 69*

Charges • 11–13, *page 69*

Application of charges • 11–14, *page 69*

Chargeable medical examinations and immunizations • 11–15, *page 71*

Use of credit cards for payment • 11–16, *page 71*

Billing and reporting procedures • 11–17, *page 71*

Negotiable instruments • 11–18, *page 71*

Internal controls • 11–19, *page 71*

Chapter 12

Patients' Trust Fund, *page 75*

Purpose • 12–1, *page 75*

Administration • 12–2, *page 75*

Responsibilities • 12–3, *page 75*

Transfer of funds and valuables to successor custodians • 12–4, *page 75*

Operating principles • 12–5, *page 76*

Safeguarding of funds and valuables • 12–6, *page 76*

Forms • 12–7, *page 77*

Procedures upon admission • 12–8, *page 77*

Audit • 12–9, *page 77*

Chapter 13

Injury and Illness Cases-Medical Affirmative Claims, *page 77*

General • 13–1, *page 77*

Interface and support • 13–2, *page 78*

Contents—Continued

Notification procedures • 13–3, *page 79*
Absent sick active duty personnel • 13–4, *page 79*
Medical records • 13–5, *page 79*
Medical claim forms • 13–6, *page 79*
Concurrent medical affirmative claims and Third Party Collection Program health insurance claims • 13–7, *page 81*
Civilian care furnished family members and retirees in the United States, Puerto Rico, Canada, and Mexico • 13–8, *page 81*
Civilian care furnished family members and retirees in the European command • 13–9, *page 81*
Civilian care furnished family members and retirees in areas other than the United States, Puerto Rico, Canada, Mexico, and in the European command • 13–10, *page 81*
Claims for reimbursement for civilian care • 13–11, *page 82*
Care in medical treatment facilities of a foreign government • 13–12, *page 82*

Chapter 14

Third Party Collection Program, *page 82*

Policy • 14–1, *page 82*
Health care plans not subject to the Third Party Collection Program • 14–2, *page 82*
Medical services billed • 14–3, *page 82*
Medical services not billed • 14–4, *page 82*
Identification of beneficiaries who have other health insurance • 14–5, *page 82*
Mandatory compliance by health insurance carriers • 14–6, *page 83*
Authorization to release medical information in support of the Third Party Collection Program • 14–7, *page 83*
Claims activities • 14–8, *page 83*
Collection activities • 14–9, *page 84*
Minimum internal controls • 14–10, *page 84*
Third Party Collection Program reports • 14–11, *page 85*
Disposition of claims files • 14–12, *page 85*

Chapter 15

Customer Service Division/Patient Administration Systems and Biostatistics Activities, *page 85*

Authority • 15–1, *page 85*
Standard Inpatient Data Record • 15–2, *page 85*
Data system studies • 15–3, *page 86*
Abortion Statistics Report (RCS MED-363) • 15–4, *page 86*
Diagnostic and operative indices • 15–5, *page 86*
Workload report • 15–6, *page 86*
Enabling Care/Patient Tracking System • 15–7, *page 86*
Patient administration contingency operations • 15–8, *page 86*
Ambulatory Data System • 15–9, *page 87*
The Army Central Registry • 15–10, *page 87*

Appendixes

- A.** References, *page 88*
- B.** Persons Authorized Care at Army MTFs, *page 97*
- C.** Management Control Evaluation Checklists, *page 112*

Table List

Table 2–1: Supplemental care payment responsibilities: Payment for civilian outpatient care, including diagnostic test and procedures, ordered by an MTF provider, *page 7*
Table 2–2: Supplemental care payment responsibilities: Payment for care when a beneficiary is admitted to a civilian facility, *page 8*
Table 2–3: Supplemental care payment responsibilities: Payment for care when a beneficiary is an inpatient in a military treatment facility (See note), *page 8*
Table 7–1: Distribution of medical board proceedings (See notes 1 and 2), *page 59*

Contents—Continued

Table B-1: Persons Authorized Care at Army MTFs, *page 97*

Figure List

Figure 3-1: OWCP address list, *page 32*

Figure 3-2: Sample format memorandum for Secretary of the Army designees, *page 33*

Figure 9-1: Uniformed Services Family Health Plan locations, *page 65*

Figure 11-1: Sample memorandum format for MSA transfer certificate, *page 72*

Figure 11-2: Sample memorandum format for MSAO discontinuance statement, *page 73*

Figure 11-3: Sample memorandum format for statement of outgoing custodian, *page 74*

Figure 11-4: Sample memorandum format for statement of new custodian, *page 74*

Glossary

Index

Chapter 1

Introduction

1–1. Purpose

This regulation assigns responsibilities and provides guidance on patient administration in Army regional medical commands (RMCs) and military treatment facilities (MTFs).

1–2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the glossary.

1–4. Responsibilities

a. The Surgeon General (TSG) develops policies governing the provision of patient administrative services for U.S. Army MTFs worldwide.

b. Major overseas commanders and commanders of U.S. Army Medical Commands are responsible for the administration of patients receiving care in MTFs under their jurisdiction.

c. RMC and MTF commanders are responsible for the administration of patients receiving care under their jurisdiction.

d. Patient administrators provide guidance on policies, procedures, and practices prescribed in this regulation.

Chapter 2

Patient Policies

2–1. Eligibility verification

The Military Installation Identification Card Issuance Activity establishes an individual's eligibility for medical care. The commander of an Army MTF will confirm the patient's identity and verify entitlement through the Defense Enrollment Eligibility Reporting System (DEERS) or identification (ID) card verification. Eligibility issues will be referred to the patient administrator.

2–2. Identification procedures

a. All persons, including soldiers in uniform, must show satisfactory evidence of their beneficiary status. A valid ID card and enrollment in DEERS will establish beneficiary status. Children under age 10 must be enrolled in DEERS, but are not routinely issued an ID card. Secretary of the Army designees are issued a letter from the U.S. Army Medical Command (USAMEDCOM) or the MTF commander where designee status has been delegated, (see para 3-50) which establishes their beneficiary status. They are not enrolled in DEERS and will not have an ID card. Discharged female members who require maternity care establish beneficiary status with a copy of their DD Form 214 (Certificate of Release or Discharge from Active Duty).

b. Types of Uniformed Services ID cards (AR 600-8-14) are as follows:

(1) DD Form 2A(ACT) (Active Duty Military ID Card) (green for active duty (AD)), red for Reserve Component (RC), and gray or blue for retirees).

(2) DD Form 1173, (Uniformed Services Identification and Privilege Card), (tan, for family members, civilian overseas, and foreign military personnel/family members).

(3) Public Health Service (PHS) Form 1866-1 (Commissioned Officers Identification Card-Active Duty) for the Commissioned Corps of the PHS, and PHS Form 1866-2 (Commissioned Officers Identification Card-Inactive Reserve) for Reserve PHS personnel. The forms are for informational purposes only.

c. MTF personnel will not provide routine care to patients with questionable eligibility. When proper identification is not available and no emergency exists, a statement of eligibility should be initiated by the MTF personnel and signed by the sponsor prior to delivery of care. The statement of eligibility will be forwarded to the MTF medical services accountable officer (MSAO). If proof of eligibility is not provided within 30 days, the patient will be billed as an emergency nonbeneficiary. In an emergency, medical care will be rendered before eligibility determination. Ineligible patients will be treated only during the period of the emergency. (See para 3-55.)

2–3. Priorities

When an MTF commander must refer care to eligible beneficiaries because of a temporary lack of access, a priority system will be used as specified in a through c below. The MTF commander must coordinate care for all beneficiaries based upon access and capabilities. Beneficiaries enrolled in the TRICARE Prime option at an MTF are provided space-required care and not space-available care in compliance with the TRICARE access standards. Beneficiaries

participating in the TRICARE Standard and Extra options are provided space-available care in MTFs. The medical or dental Army MTF commander will have final authority regarding whether or not a beneficiary will be seen in the facility. A nonavailability statement for authorized nonemergency inpatient care is required for non-enrolled Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) beneficiaries. The first level of appeal for decisions surrounding nonavailability statement issuance is the MTF commander, the second level appeal is the RMC commander, and the third and final level of appeal is the USAMEDCOM (MCHO-CL-M).

a. General rule. Among the following beneficiary groups, access priority for care in MTFs where TRICARE is implemented will be as follows:

- (1) AD members;
- (2) AD members' family members who are enrolled in TRICARE Prime;
- (3) Retirees, their family members and survivors who are enrolled in TRICARE Prime;
- (4) AD members' family members who are not enrolled in TRICARE Prime; and
- (5) Retirees, their family members and survivors who are not enrolled in TRICARE Prime.

b. Special provisions. In applying the general rules, the following special provisions are applicable:

(1) Military members not on AD but entitled to MTF care, are associated with priority group 1. This includes RC members entitled to medical care relating to conditions incurred in the line of duty (LD) and members on the temporary disability retired list (TDRL) for required periodic medical examinations.

(2) North Atlantic Treaty Organization (NATO) and other foreign military members who are entitled to MTF care pursuant to an applicable international agreement are associated with priority group 1 for the scope of services specified in the agreement.

(3) NATO and other foreign military members' family members who are entitled to care pursuant to an applicable international agreement are associated with priority group 2 for the scope of services specified in the agreement.

(4) Survivors of sponsors who die on AD, as provided in section 1076(a), title 10, United States Code (10 USC 1076(a)), are, for purposes of MTF access, considered together with dependents of AD members. They would, therefore, be in priority group 2 or 4, depending on Prime enrollment status.

(5) Individuals other than those in any of the beneficiary groups identified in priority groups 1 through 5 do not have priority access.

(6) Priority access rules are not applicable to bona fide medical emergencies or cases in which the provision of certain medical care is required by law or applicable Department of Defense (DOD) Directive or Instruction. This includes care for civilian employees exposed to health hazards in the workplace or injured on the job.

c. Exceptions to general rules. In the following instances, MTF commanders have discretion to grant exceptions to priority access rules.

(1) A higher priority may be given to a secretarial designee, to the extent appropriate to the context in which secretarial designee status is given.

(2) A higher priority may be given to an AD members' family member who is in priority group 4 owing to the unavailability of TRICARE Prime at the place of the sponsor's assignment (for example, a remote continental United States (CONUS) or outside the continental United States (OCONUS) location), when the family member is temporarily in a location where TRICARE has been implemented and needs medical care.

(3) To the extent authorized by the ASD(HA) for the particular graduate medical education (GME) program or MTF involved, after coordination with the TRICARE Lead Agent, a patient may be given a higher priority if necessary to maintain an adequate clinical case mix for GME programs functioning in the MTF or for readiness-related medical skills sustainment activities. Mechanisms to implement this policy could include identification of space available to carry out specific procedures or treat specific clinical diagnoses, or, in unique circumstances, provision for assignment to primary care managers (PCMs) of a limited number of individuals not eligible for TRICARE Prime enrollment.

(4) A higher priority may be given in other unexpected or extraordinary cases, not otherwise addressed in this policy, in which the MTF commander determines, in coordination with the TRICARE Lead Agent, that a special exception is in the best interest of the military health system and TRICARE.

(5) In overseas locations, other exceptions may be established to the extent necessary to support mission objectives.

(6) Other priority groupings are not authorized.

2-4. Primary care management

AD soldiers are assigned a PCM. (See glossary.) The soldier will report to the PCM for sick call (AR 40-66). Nonactive duty (NAD) TRICARE eligible beneficiaries, who choose to enroll, will be assigned a PCM. Other categories of beneficiaries may also be assigned PCMs as approved by the Army MTF commander.

2-5. NATO STANAG/ABCA QSTAG/SOLOG agreements

This regulation implements NATO standardization agreements (STANAGs) 2061, 2101, 2132, and 3113; American, British, Canadian, and Australian (ABCA) Quadripartite Standardization Agreement (QSTAG) 470; and Standardization of Certain Aspects of Operations and Logistics (SOLOG) 74 in chapters 3 and 4.

2-6. Commercial transportation or travel and nonmedical attendant travel

a. The cost of commercial or privately owned transportation and per diem for Army AD soldiers and required attendants for the purpose of receiving outpatient medical or dental care is chargeable to the operating funds of the unit to which the member is assigned. This policy applies to members assigned to Army activities worldwide and those assigned to other departments or agencies in CONUS. Inpatient travel is funded by the operational funds of the MTF.

b. A medical officer may recommend that a family member be accompanied by a nonmedical attendant (NMA). The NMA is warranted when the family member is not able to travel alone because of physical or mental incapacity or age. In CONUS, only the AD soldier may be an attendant to the family member with the exception of travel to specialized treatment services (STSs). (See para 2-6e.) The AD soldier is entitled to reimbursement for costs of transportation and enroute per diem; there is no entitlement at the treatment site. The unit commander of the AD soldier determines if, and for how long, a member may perform NMA duties. The NMA duties may be performed in an ordinary leave status, funded temporary duty (TDY) by MTF with concurrence of resource management, or permissive TDY status. Travel of the AD soldier's dependents stationed OCONUS is authorized for medical care. Dependent travel from or within OCONUS locations is authorized on invitational travel orders (ITOs). An NMA may be recommended by a medical officer. In OCONUS sites, anyone capable of performing the NMA duties may be assigned and reimbursed for costs of transportation and expenses at the treatment location (Joint Federal Travel Regulation (JFTR)).

c. A medical officer may recommend that an AD soldier or dependent of an AD soldier, and TDRL personnel, (but not a retiree-except a retiree on the TDRL as noted in AR 635-40-nor a dependent of a retiree) be accompanied by an NMA. A soldier may serve as an NMA. Family members or other nonmilitary persons may receive travel reimbursement as an NMA for escorting AD members CONUS or OCONUS. Family members or other nonmilitary persons may receive travel reimbursement for escorting AD dependents OCONUS. An AD soldier may be reimbursed for travel and per diem expenses while serving as an NMA. The unit commander determines if, and for how long, a soldier may perform NMA duties. A soldier may perform NMA duties in an ordinary leave status, permissive TDY, or in a funded TDY status. When NMA duties are authorized with Government funds for AD outpatients, the costs of lodging and per diem are chargeable to operational funds of that soldier's unit. For AD inpatients, travel and per diem and expenses of NMAs are chargeable to MTF funds (JFTR, volume 1, paragraph U7550-6, and Joint Federal Travel Technical Messages 5-93, 7-93, and 7-97).

d. Retired members and their dependents have no financial entitlement for their travel except TDRL members when they are reporting to the MTF for TDRL re-examination. Travel may be accomplished on Government transportation on a space-available basis.

e. In those cases where it is financially advantageous for the Government to treat a patient in an STS facility, an attendant may be authorized when a patient is unable to travel unattended. The attendant may be any person suitable to perform the required attendant duties; this person may be reimbursed for travel expenses. Entitlement is defined in JFTR, Volume 1, paragraph U-7950 and U-7951.

2-7. Medical examinations for insurance purposes

Subject to access and available resources, examinations may be provided for those authorized persons defined in chapter 3. The examinee is entitled to a written report of the examination. Insurance companies will be charged search and copying fees when a request for a report of examination is received.

2-8. Maternity care for active duty members

Army soldiers who become pregnant while on AD and who remain on AD are authorized maternity care in Uniformed Services MTFs. They are also authorized maternity care from civilian sources as described in a and b below.

a. *Physical limitations of pregnant soldiers.* A pregnant soldier will continue to perform duties, limited by physical profile as outlined in AR 40-501. If the member remains at her duty station, maternity care will be provided at the MTF serving the station if obstetrics and gynecology (OB/GYN) services are available and the member resides and works within 50 miles of the MTF. Active duty members (ADMs) who reside and work more than 50 miles from an MTF are required to enroll in the TRICARE Prime Remote Program (TPRP). As a general rule, pregnancy care for soldiers enrolled in TPRP will be provided locally by a TRICARE-authorized civilian provider. Upon discharge from the hospital following delivery and when medically indicated, the member may, upon recommendation of the attending physician, be granted convalescent leave per AR 600-8-10.

b. *Maternity care while in a leave status.* A pregnant soldier may elect to take leave and deliver in the vicinity of her leave address. When such leave is contemplated, the member will be counseled by the leave approving authority and local MTF PCM about requirements for obtaining maternity care from civilian sources. If the member's leave address is within 50 miles of an MTF that offers OB/GYN services, maternity care will be provided at the MTF.

c. *Existed prior to service (EPTS) pregnancy-RC members.* An RC member who is pregnant at the time of entry on active duty for training (ADT) for a period of 30 days or less is authorized only emergency care for that pregnancy.

2-9. Remediable physical defects developed in the military service

When a medical examination shows that an Army soldier has developed a remediable defect, the patient will be offered the opportunity of surgical repair or other medical treatment if medically indicated. If the soldier refuses surgery, other

treatment, or other diagnostic procedure, which is considered necessary to enable the person to properly perform their military duties, the provisions of AR 600-20 apply. In the case of Navy or Air Force patients, the matter will be referred to the nearest headquarters of the Service concerned. Surgical intervention will not be performed to correct a preexisting condition in the case of an RC member unless there is an LD determination that the condition was incurred or aggravated in the LD.

2-10. Hospitalization before the effective date of separation or retirement orders

When a military patient is hospitalized before the effective date of separation or retirement orders, notification procedures in AR 600-8-24 for officers and in AR 635-200 for enlisted personnel apply.

2-11. Statements of prolonged hospitalization

An MTF commander is authorized to issue a statement of prolonged hospitalization for a period exceeding 90 days (JFTR, 37 USC 554). The statement will be sent to the installation transportation officer who will instruct and assist the patient in arranging for transportation of family members and household goods. This statement is not required when the member is transferred on permanent change of station (PCS) orders from OCONUS to a CONUS MTF.

2-12. Consent by a nonmilitary patient to medical care

a. Legality of consent. Legality of consent is determined by the law of the State in which the facility is located, unless preempted by Federal law, or as modified in overseas locations by Status of Forces Agreements (SOFA).

b. Requirement for consent. A nonmilitary person may not be furnished care in Army MTFs without his or her consent or the consent of a person authorized under applicable local law, court order, or power of attorney to consent on the patient's behalf. Except for emergencies, when a patient for some reason other than a judicial determination of mental incompetency is unable to consent, consent must be obtained from the person whom local law determines is authorized to consent on the patient's behalf. When a judicial determination of mental incompetency has been made, consent must be obtained from the person whom the court appoints to act for the incompetent patient. In the absence of any governing State law provision regarding surrogate consent, the consent of the spouse or next of kin is required. Questions concerning consent requirements or authority to consent will be referred to the servicing Staff Judge Advocate (SJA) or legal advisor.

c. Form of consent. Consent may be either express or implied.

(1) *Implied consent.* Implied consent may be inferred from actions of the patient, or other circumstances, even though specific words of consent are not used. For example, a patient's application for admission to an MTF is implied consent to hospitalization. If the patient is a minor incapable of giving consent, implied consent of the parent or guardian may be found in actions of the parent or guardian requesting or not objecting to medical care for the minor. Moreover, consent to treatment is implied in certain emergency situations when patients are incapable of giving or denying consent and their condition represents a serious or imminent threat to life, health, or well-being.

(2) *Express consent.* Express consent involves a statement of consent to proposed medical care made by the patient or person authorized to act on the patient's behalf. Express consent may be valid whether it is oral or in writing. However, written consent must be obtained for both inpatients and outpatients before performing the procedures outlined in d below.

(3) *OF 522 (Medical Record-Request for Administration of Anesthesia and for Performance of Operations and Other Procedures).* This form will be used to record express written consents. (See d and e below.) Keep a record to document consent when there are local legal consent requirements that cannot be adequately captured on OF 522.

(4) *DA Form 4359-R (Authorization for Psychiatric Service Treatment).* This form will be used for admission of patients to psychiatric treatment units. In such cases, OF 522 will also be completed.

d. Procedures requiring written consent. Requests for the procedures in (1) through (7) below must be recorded on OF 522. (In the case of dental care, one OF 522 may be used to record a complete course of treatment, as appropriate.) Any questions about the necessity or advisability of a written consent should be resolved in favor of obtaining a written consent.

(1) All surgery involving entry into the body by an incision or through one of the natural body openings.

(2) Any procedure or course of treatment in which anesthesia is used, whether or not entry into the body is involved. This includes dental procedures involving the use of either general anesthetic, intravenous sedation, or nitrous oxide sedation.

(3) All nonoperative procedures that involve more than a slight risk of harm to the patient or that involve the risk of a change in body structure.

(4) All procedures in which x ray, radiation, or other radioactive substance is used in the patient's treatment.

(5) All procedures that involve electroshock therapy.

(6) All transfusions of blood or blood products.

(7) All other procedures that, in the opinion of the attending physician, dentist, chief of service, clinic chief, or the commander, require a written consent.

e. Counseling before obtaining consent. The physician, dentist, or other health care provider/practitioner who is to

perform or supervise the procedure will counsel the patient or the consenting person as appropriate to provide the basis for an informed consent. (See legal requirements in f below.) In written consents, any exceptions to surgery or other procedures made by the consenting person will be recorded by the health care provider/practitioner on OF 522. When all the data in Parts A and B of OF 522 are completed, the counseling must be attested to by signatures of the counseling health care provider/practitioner and the consenting person in Part C of OF 522.

f. Sufficiency of consent. The consenting person must be legally capable of giving consent and must understand the nature of the procedure, the attendant risks, expected results, possible alternative methods of treatment, and the prognosis if treatment is not given. Legality of consent is determined by the law of the State in which the facility is located, unless preempted by Federal law or as modified in overseas locations.

g. Nonmilitary minors. The sufficiency of consent by a nonmilitary minor to medical or dental examinations or treatment will be determined under the same criteria as provided in f above. Most States have laws concerning consent by minors. Many States allow the treatment of venereal disease and certain other conditions with the consent of the minor alone, without parental knowledge or consent. If no law exists on the subject or if the law does not specifically prohibit consent by a minor, the maturity of the minor should dictate whether he or she may give a legally sufficient consent. The health care provider/practitioner obtaining the consent will determine the maturity of the minor. The minor's age, level of intelligence, and the minor's understanding of the complications and seriousness of the proposed treatment are all factors to consider when determining the maturity of the minor. When the minor's consent alone is legally sufficient, the minor's decision to authorize or reject the proposed treatment is binding. Even when the minor's consent alone is not legally sufficient, his or her consent should be obtained along with the parent's consent whenever the minor is able to understand the significance of the proposed procedures. If there is a question as to the sufficiency of the minor's consent, the servicing SJA or legal advisor will be consulted.

(1) If not prohibited under the laws of the State in which the MTF is located, parents may grant powers of attorney to authorize other persons to consent to medical care for minor children. Mature minor children may be granted authority to consent to care for themselves and other minor children of the family or to other persons appointed by the parents or legal guardian. Members of Army MTF staff may not accept appointment as a special attorney for this purpose unless based solely on a personal relationship with the sponsor. A health care provider/practitioner who accepts such appointment will not consent to any treatment he or she authorizes or performs unless approved by the MTF commander or designee.

(2) Persons who wish to execute a power of attorney will be referred to the appropriate SJA or legal office for assistance.

h. Military minors. Members of the Uniformed Services who would otherwise be minors under local law are considered to be emancipated and capable of consent as if they were adults, subject to command aspects of medical care for AD soldiers as described in AR 600-20.

i. Sterilization of mental incompetents. A determination of the specific authority of parents, courts, or other third parties to consent to or authorize the sterilization of mental incompetents in the State where the MTF is located will be coordinated with the local SJA or servicing legal advisor before performing the procedure.

j. Psychiatric disorders.

(1) The MTF commander may temporarily detain, without a court order or consent, nonmilitary beneficiaries with a psychiatric disorder which makes them dangerous to themselves or others when such person is found on the military reservation where the MTF is located. Temporary involuntary detention will conform with local law, and the local civilian authorities will be notified immediately upon detention of a nonmilitary psychiatric patient.

(2) Movement of nonmilitary psychiatric persons without proper consent or court order normally will not be done under the auspices of an Army MTF.

(3) The validity of a court order directing involuntary confinement or treatment of a patient in an Army MTF is a matter for review, in each instance, by the proper SJA or legal advisor.

(4) See paragraph 5-23 concerning evacuation of nonmilitary psychiatric patients in foreign countries.

k. Advance directives (living wills and durable powers of attorney for health care). (AR 40-3, chap 2).

l. Autopsy consent. (See para 6-5.)

2-13. Patient transfers

Patients will be treated at the lowest echelon equipped and staffed to provide required medical care consistent with evacuation policies. When required care is not available, patients will be transferred to the nearest Armed Forces MTF or other Federal MTF for which they are eligible that has the required capability. The patient may also be referred to TRICARE service centers for coordination/assistance related to transfers. Government transportation of the military patient and one or more attendants, if required, is authorized. DA Form 3981 (Transfer of Patient) or a medical staff approved locally developed form may be used to communicate among the transferring physician and other MTF staff elements. DA Form 3981 is available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web (WWW.usapa.army.mil).

2-14. Care beyond an MTFs capability

a. Health care services are authorized to eligible beneficiaries in three ways. First is the direct care system where all DOD beneficiary categories are entitled to receive health care benefits, with AD soldiers having priority access to care. (See chaps 2 and 8.) Second, DOD is authorized to contract for health care services from Governmental and non-Governmental health care sources with reimbursement to participating providers/practitioners under the TRICARE Program. Third, under the Supplemental Care Program, DOD may use funds to obtain civilian health care for eligible beneficiaries when that care is not available in the MTF. The primary use of supplemental care is to ensure that AD soldiers receive all necessary health care services. The process for obtaining civilian specialty and inpatient care through the Supplemental Care Program for AD members will be the same as that established for NAD TRICARE Prime enrollees. The PCM is responsible for referring the patient for specialty care, and the health care finder arranges for civilian care in the contractor's TRICARE network if the care is not available in the MTF. The managed care support (MCS) contractor will then adjudicate the claim in the same fashion as applied to other TRICARE Prime enrollees except that a copayment will not be applied. The MTF will retain clinical responsibility for the AD member via the PCM and administrative oversight of supplemental care payment issues will remain a responsibility of the MTF commander. The reimbursement for care beyond the MTFs capability will be according to tables 2-1 through 2-3.

b. Supplemental care on an inpatient basis will be carefully monitored through the hospital utilization management program.

c. AD patients receiving inpatient supplemental care in another facility will not be counted as occupying a bed in an Army MTF but will be continued on the inpatient census. Also, the patient will be accounted for under "change of status out." (See chap 3.)

d. Under TRICARE, the MCS contractor's health care finder will assist with referrals to network providers, where available. If a network provider is not available, the referral will be made to a TRICARE authorized provider. This includes AD referrals. All medical services requested under TRICARE must be reviewed for medical necessity as required by the MCS contract prior to approval by the MTF. Emergencies are exempt from this requirement.

e. The MCS contractors will process all claims for AD. Claims of RC soldiers for medical care associated with LD injuries or illnesses will be processed using the same procedures.

f. The authority for all Department of Veterans Affairs (VA)/DOD Health Care Resources Sharing Program Agreements is Public Law 97-174. Provisions of the memorandum of understanding between the VA and DOD entitled, VA/DOD Health Care Resources Sharing Guidelines, dated 29 Jul 83 apply.

2-15. Admission of psychiatric patients

Beneficiaries may be admitted to closed psychiatric wards when they have a mental illness that renders them dangerous to themselves or others.

a. Nonmilitary patients. All psychiatric patients should meet Mental Health Service Intensity criteria before being admitted. Psychiatric patients will not be provided prolonged hospitalization or domiciliary care.

b. Military family members. Family members will not be admitted to an Army MTF when their needs are only for domiciliary or custodial care. Family members may be hospitalized for chronic conditions and nervous, mental, and emotional disorders that require active and definitive treatment. Admission will be according to the order of priority in paragraph 2-3.

2-16. Ancillary medical services

Ancillary services (for example, pharmacy services, medical laboratory procedures, immunizations, and medical x rays) may be provided to family members and retired members who receive care from civilian sources subject to the availability of space, facilities, and the capabilities of the professional staff.

2-17. Family planning services

a. Family planning services (for example, counseling, prescription of oral contraceptive pills, and prescription of other methods of contraception) may be furnished to eligible persons requesting such care at Army MTFs. They will be provided to the extent that professional capabilities and facilities permit. When capability is limited or absent, referral to other agencies at no expense to the Government may be arranged through the MTF social work service.

b. Surgical sterilization may be performed in Army MTFs subject to the availability of space and facilities and the capabilities of the medical staff. Prior written consent will be obtained from the patient. (See para 2-12.) Also see paragraph 2-12 for special consideration relative to sterilization in the case of mental incompetents.

2-18. Abortions

a. Abortions may be performed in Army MTFs at Government expense only when the life of the mother would be endangered if the fetus were carried to term.

b. Eligible beneficiaries may obtain abortions in overseas Army MTFs on a prepaid basis only if the pregnancy is the result of rape or incest. Prepaid abortions for rape and incest are not available in stateside Army MTFs. Charges for prepaid abortions for all beneficiaries, including AD soldiers, will be based on the established full reimbursement rate

for same-day surgery for the particular category of patient. The laws of the host nation apply when performing abortions under this paragraph.

c. Abortions for other than AD soldiers will be subject to the availability of space and facilities and the capabilities of the professional staff. Abortion procedures are also subject to the priorities listed in paragraph 2-3. Written consent of the patient is required before the procedure. Consent of unemancipated minors will be obtained according to paragraph 2-12. After an abortion, any restrictions or limitations needed for AD soldiers will be determined by the proper medical authority under AR 40-501, chapter 7.

d. Medical care in Army MTFs as authorized by paragraph 3-39 for former soldiers who are pregnant at the time of separation may include abortions as authorized in a and b above. Follow up and initial family planning counseling may also be furnished if indicated. Transportation for such care will be at the former soldier's expense.

e. Aeromedical transportation may be provided on a prepaid basis (that is, the patient pays the cost of the service in advance) to eligible beneficiaries for abortions or abortion consultation services under the following conditions.

(1) For OCONUS sites, intratheater aeromedical transportation is authorized for AD soldiers and other beneficiaries in overseas areas who do not qualify for abortions at Government expense when there is a lack of access to acceptable civilian health care facilities for abortion or abortion consultation due to cost, unavailability of transportation, or cultural and language barriers. In these cases, the abortion or abortion consultation services may be performed at the nearest capable MTF on a prepaid basis.

(2) In CONUS, aeromedical transportation is authorized for AD soldiers who do not qualify for abortions at Government expense if they require professional abortion consultation which is not available locally.

f. Army Medical Department (AMEDD) personnel do not have to perform or take part in procedures authorized by this paragraph that violate their moral or religious principles. Moral or religious objections will be considered as lack of capability to provide this care.

g. When an Army MTF does not have the space, facilities, or staff capability to perform authorized sterilization and abortion services, arrangements should be made to provide these procedures as follows.

(1) Eligible beneficiaries may be transferred to another MTF where these services can be provided. Enrolled beneficiaries may obtain these services under provisions of the TRICARE Program.

(2) AD soldiers may be transferred to another MTF where these services can be provided. They may also obtain these procedures from civilian sources under provisions of chapter 9 only when competent medical authority has determined that the procedure is required for urgent medical reasons. Elective care for AD soldiers from civilian sources at Government expense is prohibited.

2-19. Cosmetic surgery

a. For AD soldiers, medical intervention should be based upon a medical need adjunctive to the patient's health status. Availability of cosmetic surgery is dependent upon the educational and clinical skills maintenance needs of the Army. Elective cosmetic surgery charges for nonmilitary patients are found in the annual fiscal year (FY) medical, dental, and subsistence rates for Army MTFs.

b. For other than AD soldiers, the following apply.

(1) The number of procedures performed will be those that 50 percent to 70 percent of training programs provide per resident as reported by the Residency Review Committee in plastic surgery.

(2) The procedures will only be performed by residents in specialties requiring cosmetic surgery for their boards (plastic surgery, ear, nose, throat, ophthalmology, dermatology, and oral surgery), junior staff preparing for board eligibility, and staff certified in those specialties in order to maintain their skills and proficiency.

(3) These procedures will only be performed in hospitals that have applied for or have attained designation as an STS facility according to DOD guidance.

Table 2-1
Supplemental care payment responsibilities: Payment for civilian outpatient care, including diagnostic test and procedures, ordered by an MTF provider

| Beneficiary category | TRICARE Prime copayment | TRICARE Extra /Standard cost shares & deductibles | Supplemental care | Social Security Health Insurance Program for the Aged (Medicare)-eligible and other non-TRICARE eligibles |
|----------------------------|-------------------------|---|-------------------|---|
| AD TRICARE Prime Enrollee | | | X | |
| NAD TRICARE Prime Enrollee | X | | | |

Table 2-1
Supplemental care payment responsibilities: Payment for civilian outpatient care, including diagnostic test and procedures, ordered by an MTF provider—Continued

| Beneficiary category | TRICARE Prime copayment | TRICARE Extra /Standard cost shares & deductibles | Supplemental care | Social Security Health Insurance Program for the Aged (Medicare)-eligible and other non-TRICARE eligibles |
|---|-------------------------|---|-------------------|---|
| Non-Enrolled TRICARE-eligible Beneficiary | | X | (See note 1.) | (See notes 2 and 3.) |

Notes:

¹ Supplemental care funds are not appropriate; for TRICARE-eligible beneficiaries, cost sharing is based on both the beneficiary category and the health care option selected.

² Medicare-eligibles not participating in a DOD Medicare demonstration project should use their Medicare benefit to receive care from civilian sources. Payment for other non-TRICARE-eligibles should be at the discretion of the MTF Commander, based on other program and statutory requirements.

³ Medicare-eligibles not participating in a DOD Medicare demonstration project should use their Medicare benefit to receive care from civilian sources. Payment for other individuals not eligible to enroll in TRICARE Prime should be at the discretion of the MTF commander, based on other program and statutory requirements such as SOFA, responsibility for performing physical examinations for those otherwise not eligible for care, etc.

Table 2-2
Supplemental care payment responsibilities: Payment for care when a beneficiary is admitted to a civilian facility

| Beneficiary category | TRICARE Prime copayment | TRICARE Extra / Standard cost shares & deductibles | Supplemental care | Medicare-eligible and other non-TRICARE eligibles |
|---|-------------------------|--|-------------------|---|
| AD TRICARE Prime Enrollee | | | X | |
| NAD TRICARE Prime Enrollee | X | | | |
| Non-Enrolled TRICARE eligible Beneficiary | | X | (See note 1.) | (See notes 2 and 3.) |

Notes:

¹ Supplemental care funds are not appropriate; for TRICARE-eligible beneficiaries, cost sharing is based on both the beneficiary category and the health care option selected.

² Medicare-eligibles not participating in a DOD Medicare demonstration project should use their Medicare benefit to receive care from civilian sources. Payment for other non-TRICARE-eligibles should be at the discretion of the MTF Commander, based on other program and statutory requirements.

³ Medicare-eligibles not participating in a DOD Medicare demonstration project should use their Medicare benefit to receive care from civilian sources. Payment for other individuals not eligible to enroll in TRICARE Prime should be at the discretion of the MTF commander, based on other program and statutory requirements such as SOFA, responsibility for performing physical examinations for those otherwise not eligible for care, etc.

Table 2-3
Supplemental care payment responsibilities: Payment for care when a beneficiary is an inpatient in a military treatment facility (See note)

| Beneficiary category | TRICARE Prime copayment | TRICARE Extra /Standard cost shares & deductibles | Supplemental care |
|---|-------------------------|---|-------------------|
| AD TRICARE Prime Enrollee | | | X |
| NAD TRICARE Prime Enrollee | | | X |
| Non-Enrolled TRICARE- eligible Beneficiary | | | X |
| Medicare-eligible and other non-TRICARE eligibles | | | X |

Notes:

Supplemental care payments are authorized in all cases since the MTF maintains full clinical responsibility for the inpatient. Obtaining civilian care while the beneficiary is in an inpatient status is not a common practice, but supplemental care payments are used to pay for tests or procedures such as a magnetic resonance imaging (MRI) performed while a patient is an inpatient in a Uniformed Services facility. Since the patient is responsible for inpatient charges, applying outpatient copayments/cost shares is not appropriate.

Chapter 3

Persons Eligible for Care in Army MTFs and Care Authorized

Section I

Members of the Uniformed Services

3-1. Members of the Uniformed Services on active duty

Members of the Uniformed Services on AD are authorized care under 10 USC 1074a. This includes RC members who are on AD; cadets of the U.S. Military, Air Force, and U.S. Coast Guard (USCG) academies; and Midshipmen of the U.S. Naval Academy.

3-2. Members of the Uniformed Services Reserve Components

The provisions of this paragraph concerning status and treatment after expiration of a period of AD or full-time National Guard (NG) duty orders, or inactive duty training (IDT) exclude those RC personnel who are retained in a patient status beyond the termination of orders according to AR 135-381.

a. Treatment during and after duty. RC members on AD or full-time NG duty or IDT are authorized medical and dental care in Army MTFs for injury, illness, or disease incurred or aggravated in the LD while performing that duty or while traveling directly to or from the duty.

(1) While on AD or full-time NG duty orders for more than 30 days, RC personnel are authorized health care on the same basis as the active component.

(2) After expiration of the period of duty, RC personnel are authorized medical and dental care only for conditions incurred or aggravated in LD while on that training/duty or while traveling directly to or from such training/duty. (AR 135-200 addresses administrative procedures to be carried out at the time of expiration of the training or duty.)

(3) While on IDT, AD, or full-time NG duty for 30 days or less, RC personnel are authorized medical and dental care as a result of injury, illness, or disease incurred or aggravated incident to IDT or ADT (AR 135-381).

(4) Health care authorized for persons in (3) above will be provided until the resulting disability from covered disease or injury cannot be materially improved by further hospitalization or treatment.

(5) While not on duty and while voluntarily participating in aerial flights in Government-owned aircraft under proper authority and incident to training, RC members are authorized medical and dental care required as the result of an injury incurred in LD.

b. Status after period of duty. Upon expiration of the AD or full-time NG duty orders or the IDT period, RC members are released from duty. While receiving treatment after expiration of the IDT or duty specified in orders, members are in a patient status but not on AD. Provisions of AR 135-381 may apply.

c. Training under other conditions. Upon presentation of official authorization (see d(2) below), individuals in (1) and (2) below may be hospitalized in or transferred to an Army MTF to appear before a medical evaluation board (MEB) and a physical evaluation board (PEB), if indicated, as provided in AR 635-40.

(1) Individuals undergoing hospitalization in other Federal MTFs or civilian hospitals.

(2) Individuals not in a hospital status where it appears that they are disqualified for further military service as a result of a condition incurred or aggravated in LD.

d. Authorization for care of personnel on duty for 30 days or less, those on IDT, and Reserve Enlistment Program of 1963 (REP 63) personnel.

(1) When the initial treatment is accomplished during a period of authorized duty and medical care is continued after expiration of the duty period, written authorization from the RC unit is not required, but written consent from the patient is required. Personnel on duty for 30 days or less are not enrolled in TRICARE Prime.

(2) In all other cases, the individual will be required to present an official authorization for treatment as follows.

(a) Authorization issued by the respective State Adjutant General or his or her designee, in the case of a member of the Army or Air Force NG who suffered injury or contracted disease while performing training duty in his or her NG status.

(b) Authorization issued to members of the RC by the unit commander. For individuals who were in training status but not assigned to a unit, the U.S. Army Reserve Personnel Center (ARPERCEN) will issue authorization. The provisions of this paragraph also apply in the case of REP 63 personnel of the NG.

(c) Authorization from the Bureau of Medicine (BUMED) and Surgery, Department of the Navy, for members of the Naval Reserve and Marine Corps Reserve.

(d) Authorization from the individual's unit commander for Air Force Reserve personnel.

(3) Prior written request from the person's unit commander is required for treatment of Army and Air Force RC personnel injured while on IDT and for admission of members of the Naval Reserve, Marine Corps Reserve, and USCG Reserve who suffer injury or contract disease while on IDT.

(4) If medical care is furnished in an emergency without the required authorization, the MTF commander will request authorization from the appropriate authority indicated in (2) above. Letters of authorization will include the

name, social security number (SSN), grade, and organization of the patient; the type and period of duty in which engaged; and the diagnosis (if known). The letter will also state that the injury suffered or disease contracted was in LD and that the patient is entitled to medical care.

e. LD determinations. When individuals are admitted to or treated at an MTF during a period of training duty under doubtful LD conditions, the MTF commander will ensure that an LD is initiated. The MTF commander will be furnished a copy of the final determination (to include a report of investigation, when made). In injury cases where LD may be questionable, LD investigation should be requested promptly. Non-emergent surgical intervention will be deferred for suspected preexisting conditions of RC personnel until there is an LD determination that the condition was incurred or aggravated in LD.

(1) If the investigation results in a not in line of duty (NLD) determination before the date of expiration of the training period, every effort will be made to disposition hospitalized individuals by the expiration date or as soon as they become transportable. Care for NLD conditions will be provided only to the extent necessary. Such persons are not authorized medical care at Government expense after expiration of their training period. The cost of any care furnished after the expiration date will be collected at the civilian emergency rate from the individual by the MTF concerned. (See app B and chap 10.)

(2) If the investigation results in an approved NLD determination, the soldier is furnished medical care without charge (except for subsistence) up until such time as the MTF receives notification.

f. Services authorized for LD conditions. RC personnel will be furnished necessary follow-up care for injury or disease in LD while on authorized duty. Such care includes—

(1) Medical treatment.

(2) Dental treatment.

(3) Prosthetic devices, prosthetic dental appliances, hearing aids, spectacles, orthopedic footwear, and orthopedic appliances. In addition, during the time an individual is on ADT, repair or replacement of personally owned items in this category is authorized at Government expense when the unit commander determines that the items were not damaged or lost through negligence or misconduct on the part of the individual.

g. Spectacles inserts for protective field masks. RC personnel that have an Active Army mission of manning missile sites or are designated for control of civil disturbances are authorized spectacles inserts for protective masks.

h. Periodic medical examinations. When RC medical officers are not available to perform required periodic medical examinations, Armed Forces RC personnel not on AD may be provided examinations in Army MTFs (AR 40-501). When hospitalization is necessary for the proper conduct of periodic examinations, subsistence charges will be collected as indicated in appendix B.

i. Temporary members of the USCG Reserve. See paragraph 3-24 for care available to temporary members of the USCG Reserve as beneficiaries of the Office of Workers' Compensation Programs (OWCP).

j. Continuation of pay and allowances. When an RC member is hospitalized or requires continued medical treatment for an LD condition at the expiration of his or her duty period, he or she may be entitled to continuation of pay and allowances as authorized in DOD 7000.14-R. Entitlement to pay and allowances is outlined in AR 135-381. Pay and allowances will not continue for longer than 6 months without Secretary of the Army approval. When treatment is begun during the period of duty (d(1) above) and the determination has been made that the condition was incurred in LD, the MTF commander will furnish the member's RC unit commander or the Commander, ARPERCEN, the following as applicable:

(1) Notice of hospitalization or requirement for continued medical care to include a projected end for medical care.

(2) DA Form 2173 (Statement of Medical Examination and Duty Status).

(3) A description of the member's medical condition in lay language and a specific description of duty limitations.

(4) DA Form 3349 (Physical Profile).

(5) Notice of transfer to another MTF or transfer of responsibility for continued medical care to another MTF.

(6) Notice of disability processing.

(7) Determination of the date on which the member is released from medical control.

k. Transfer of treatment responsibility. In some instances a member of an RC may be returned to his or her home for convalescence, outpatient follow up, or pending final determination of medical fitness for military Service. The member normally will be provided follow-up care at a Uniformed Services MTF or other Federal MTF within a reasonable distance of his or her home. If these facilities are not reasonably available, civilian medical care may be authorized with appropriate approval.

(1) If follow-up care is to be provided in an MTF other than the one originally providing care, the commander of the originating MTF (initial MTF providing care) will coordinate with the appropriate U.S. Army medical department activity (MEDDAC)/U.S. Army Medical Center (MEDCEN) in whose geographical area the patient resides for designation of a source of follow-up care. Upon release from the originating MTF, the member will be provided a letter of instruction ((2) below). A copy of the letter will be forwarded to the MTF which is to provide the follow-up treatment with instructions to notify the appropriate authority as described in d(2) above when the member is released from medical control.

- (2) The letter of instruction will reflect—
 - (a) Diagnosis of disease or injury.
 - (b) Date, time, place of disease or injury, status of member, and authority for status.
 - (c) Approximate period of outpatient treatment or convalescence.
 - (d) The MTF or physician providing follow-up care.

3-3. Members of the Senior Reserve Officers' Training Corps of the Armed Forces

a. Medical care in Army MTFs is authorized members of the Senior Reserve Officers' Training Corps (SROTC) of any branch of the Uniformed Services, including students who are enrolled in the 4-year SROTC Program (10 USC 2109) or the 2-year Advanced Training SROTC Program (10 USC 2104) and members enrolled as authorized by 10 USC 2103.

(1) Medical care for injury incurred or disease contracted without reference to LD while traveling to or from and while attending required field training (annual Reserve Officers' Training Corps (ROTC) training camps) under the provisions of 10 USC 2109. Medical care is also authorized for injury incurred as a result of practical military training (for example, annual training camps to include airborne and ranger training). Practical military training is normally associated with participation in Service-sponsored training, sports, and recreational activities on a military installation. See paragraph 3-46 for care authorized ROTC members who are injured or become ill while participating in extra curricular activities.

(a) Routine dental treatment will be furnished for conditions which are disabling and the result of injury or disease incurred in LD. Dental care for other conditions will be limited to emergency treatment.

(b) Prosthetic devices, prosthetic dental appliances, hearing aids, spectacles, orthopedic footwear, and orthopedic appliances will be furnished for conditions which are disabling and the result of injury or disease incurred in LD. When the camp commander or the MTF commander, if the individual is not participating in ROTC annual training camp, determines that these items were not damaged or lost through negligence on the part of the individual concerned, repair or replacement is authorized under normal outpatient care at no expense to the individual.

(c) If members of the SROTC are undergoing hospitalization upon termination of camp or the authorized period of duty covered by military orders, or if before their departure from camp they are in need of hospitalization because of a disability NLD and are medically unable to withstand transportation to their home, they may remain in or be admitted to an Army MTF. Such care is not authorized at Army expense and the cost will be collected from the members at the full reimbursable rate (see glossary) by the MTF concerned. Every effort will be made to disposition hospitalized patients at the earliest practicable date.

(2) Medical examinations and immunizations (AR 145-1).

(3) Medical care, including hospitalization, for injury incurred or disease contracted in LD while at or traveling to or from a military installation for the purpose of undergoing medical or other examinations or for visits of observation under the provisions of 10 USC 2110.

b. Medical care is not authorized during attendance at a civilian educational institution except as indicated below.

(1) Medical examinations required by AR 145-1 including hospitalization when necessary for the proper conduct of the examination.

(2) Immunizations required by AR 145-1 including hospitalization for any severe reactions resulting therefrom.

c. Members of the Naval and Air Force SROTC are authorized medical treatment, examinations, and immunizations in Army MTFs to the same extent and under the same circumstances as members of the Army SROTC.

d. Written authorization for treatment of those ROTC members referred to in *a* and *b* above will be prepared by the camp commander and will be addressed to the commander of the Army MTF concerned. DD Form 689 (Individual Sick Slip) may be used to meet this requirement.

e. For conditions under which medical care is provided at the expense of the OWCP to those ROTC members referred to in *a* and *b* above, see paragraph 3-24a(1).

Section II

Applicants

3-4. Designated applicants for enrollment in the Senior Reserve Officers' Training Program (except ROTC scholarship applicants)

Designated applicants for enrollment in the SROTC Program are students who have been designated by the Professor of Military Science for enrollment in the 4-year SROTC Program (10 USC 2107) or the 2-year Advanced Training SROTC Program (10 USC 2104). This includes those selected for the 6-week field training or practice cruise to qualify for enrollment and those selected by the Professor of Military Science for enrollment as authorized by 10 USC 2103.

a. When properly authorized, designated applicants for enrollment in the SROTC Program (including applicants for enrollment in the 2-year program and Military Science II enrollees applying for Military Science III) will be furnished medical examinations at Army MTFs-including hospitalization-when necessary for the proper conduct of the examination. They are also authorized medical care-including hospitalization-for injury incurred or disease contracted in LD

while at or traveling to or from a military installation for the purpose of undergoing medical or other examinations (10 USC 2110).

b. Designated applicants for membership in the Army, Naval, and Air Force SROTC Programs are authorized medical care in Army MTFs during the initial training period (field training/practice cruises) authorized by 10 USC 2104(b)(6) on the same basis as enrolled members of the ROTC advanced courses.

3-5. Applicants for cadetship at the Service academies and ROTC scholarship applicants

Refer to AR 40-29/AFR 160-13/NAVMEDCOMINST 6120.2/CGCOMDTINST M6120.8B.

3-6. Applicants for enlistment or reenlistment in the Armed Forces, including applicants for enlistment in the Reserve Components

Upon referral by the commander of a military entrance processing station (MEPS), applicants for enlistment or reenlistment will be furnished necessary medical examinations. Hospitalization is authorized when their medical fitness for military Service cannot be determined without hospital study. Invasive procedures carrying an unacceptable risk of adverse complications should not be undertaken. Also, definitive medical care for a potentially disqualifying medical condition should not be undertaken.

3-7. Applicants for appointment in the Regular Army and Reserve Components including members of the Reserve Components who apply for active duty

Medical examinations will be furnished according to AR 40-501 and AR 601-100. When medical fitness for appointment cannot otherwise be determined, hospitalization is authorized.

3-8. Applicants who suffer injury or acute illness

Applicants listed in paragraphs 3-3, 3-4, and 3-5 who suffer injury or acute illness while awaiting or undergoing processing at Army facilities or MEPS may be furnished emergency medical care-including emergency hospitalization-for that injury or illness.

Section III

Retired Members of the Uniformed Services

3-9. Eligible retired members

Retired members listed below are authorized the same medical and dental care as AD soldiers, subject to the availability, access, and the capabilities of the clinical staff. (See para 2-3.)

- a. Those retired for length of service.
- b. Those permanently or temporarily retired for physical disability. (See b below for exception.)

3-10. Periodic medical examinations

Periodic medical examinations for members on the TDRL including hospitalization in connection with the conduct of the examination, will be furnished on the same priority basis as AD soldiers.

Section IV

Family Members of the Uniformed Services

3-11. Care authorized family members

Family members of AD, retired, and deceased members of the Uniformed Services-to include eligible wards-are subject to the priorities and availability as defined in paragraphs 2-3 and 2-13. A family member's eligibility begins on the date that the sponsor enters on AD. It ends at midnight on the date that the sponsor's period of AD ends (for any reason other than retirement or death) (AR 600-8-24 or AR 635-200). Family members of RC soldiers on AD orders for more than 30 consecutive days are eligible for health benefits in the local military hospital and are eligible for TRICARE Standard (CHAMPUS) or TRICARE Extra where available, but not TRICARE Prime. The standard CHAMPUS copayments and deductibles apply. Authorized services include—

a. *Drugs.* Prescriptions written by military or civilian physicians, dentists, podiatrists, or any nonphysician health care provider/practitioner privileged by the MTF or licensed by the State may be filled at Uniformed Services MTFs subject to availability of pharmaceuticals and consistent with control procedures and applicable laws.

b. *Dental Care.* Family members are authorized dental care on a space-available basis. Family members enrolled in the TRICARE-Active Duty Family Member Dental Plan are not eligible for any type of care in the MTF provided by the plan; however, care is authorized as an adjunct to ongoing medical or surgical inpatient care.

3-12. Medical care not authorized family members

The following may not be provided family members in Army MTFs:

- a. Prosthetic devices including hearing aids, orthopedic footwear, and spectacles or contact lenses, except as

provided in AR 40-63/NAVMEDCOMINST 6810.1/AFR 167-3. However, these items may be sold at Government cost to family members outside the U.S. and at specific installations within the U.S. as authorized by the Secretary of the Army. Requests from installations for authorization to sell these items will be submitted through commanders of MEDCENs to the Commander, USAMEDCOM, ATTN: MCLO-S, 2050 Worth Road, Fort Sam Houston, TX 78234-6000.

b. Dental care (except as authorized in para 3-11).

c. Noneligible newborn infant. Upon admission, the sponsoring beneficiary (the delivering mother or the mother's parents) will be counseled about the charges for the care of the noneligible newborn infant and the option to apply for Secretarial designee status under paragraph 3-50. After counseling, the sponsoring beneficiary will be asked to sign a statement accepting responsibility for the newborn infant's charges.

3-13. Surviving dependents of Reserve members

Surviving dependents of Reserve members who at the time of their death were eligible for retired pay but died before reaching age 60 are eligible for MTF care and TRICARE coverage. They are eligible regardless of whether or not the member elected Survivor Benefit Plan participation.

Section V

Federal Civilian Employees and Their Family Members

3-14. Federal civilian employees

a. Emergency medical care (including initial treatment after on-the-job injury or illness) is authorized for DOD employees injured on the job, whether appropriated or nonappropriated fund.

(1) Definitive medical and surgical management of injury or illness that is the proximate result of employment will be provided an employee paid from appropriated funds as a beneficiary of the OWCP. OWCP reimbursement will be obtained according to paragraph 3-24 in the treatment of an injury which—

- (a) Requires more than first aid or palliative treatment,
- (b) Is likely to result in any disability for work beyond the day of occurrence,
- (c) Appears to require prolonged treatment,
- (d) May result in future disability, or
- (e) May result in any permanent disability.

(2) OWCP reimbursement will not be obtained for care that is limited to emergency diagnosis and first-aid treatment since these are services authorized under the Army Occupational Health Program and the Occupational Health and Safety Act.

(3) When treatment is required for other than minor injury or illness that is not the result of employment, patients will be referred to their physician for care after initial emergency treatment.

b. Medical examinations in connection with disability retirement may be furnished civilian employees of all Federal agencies without charge when such examinations are requested by authorized representatives of the Office of Personnel Management. When hospitalization is necessary to the proper conduct of these examinations, subsistence charges will be collected locally from the individual.

3-15. Occupational health services

a. At Army installations having MTFs that provide occupational health services, the following applies: Diagnosis, treatment, and other services authorized by AR 40-5 are provided to Army civilian employees paid from appropriated, nonappropriated, or Army working capital funds, and applicants for such employment by the Army, under the Army Occupational Health Program. See AR 215-1 for information on reporting job-related injuries and processing claims for workers' compensation for nonappropriated fund (NAF) employees. When hospitalization is necessary for the proper conduct of the medical examinations authorized by AR 40-5, a charge for subsistence will be collected locally from the individual. See AR 40-5 for authorized services. Medical examinations authorized for Department of the Army (DA) civilian employees are covered under the provisions of section 301, part 339, title 5, Code of Federal Regulations (5 CFR 339.301).

Note. Under the DA Alcohol and Drug Abuse Prevention and Control Program (ADAPCP), (AR 600-85), Army civilian employees may be provided on a space-available basis inpatient detoxification services in Army MTFs, outpatient clinical evaluation for ADAPCP enrollment, and outpatient rehabilitative services after ADAPCP enrollment. Charges for inpatient detoxification are provided in appendix B and will be collected locally. Outpatient clinical evaluation and outpatient rehabilitative services will be furnished without charge.

b. Civilian employees of other Federal agencies outside the DOD who are paid from appropriated, nonappropriated, or industrial funds and applicants for such employment are authorized those health services listed in AR 40-5. Except for civilian employees and prospective employees of the Navy, Marine Corps, and Air Force in the Washington, DC metropolitan area to whom authorized occupational health services are furnished as the financial responsibility of the

DA, arrangements for payment will be made locally at an estimated per capita cost. The costs will be paid at the receiving agency and handled as an automatic reimbursement by the MTF providing the service.

c. A Federal civilian employee on TDY at an Army installation will be provided occupational health services on the same basis as those employees assigned to that installation. Employees are covered for injuries occurring while engaged in activities which are essential or reasonable incidental to the employment, but not while engaged in personal or recreational activities with no relation to the employment.

3-16. Federal civilian employees and their family members outside the United States and at remote installations in the United States

a. U.S. citizens who are employees of DOD or other Federal agencies paid from appropriated, nonappropriated, or industrial funds who require treatment for conditions not covered by the OWCP (para 3-24a(2)) and who are not beneficiaries of any other Federal agency listed in this chapter and their family members may receive care in Army MTFs outside the U.S. Treatment other than that authorized OWCP beneficiaries is not provided to non-U.S. citizen employees unless the major overseas commander concerned determines that civilian facilities are not available or are not adequate.

b. DOD civilian employees and their family members may also receive care at Army installations in the U.S. that have been designated as remote by the Secretary of the Army for the purpose of providing medical care to these individuals.

c. Charges will be collected locally from the individual at the rates shown in appendix B except that no charge will be made for immunizations and reimmunizations authorized by AR 40-562/AFJI 48-110/BUMEDINST 6230.15/CG COMDTINST M6230.4E or for occupational health services authorized by paragraph 3-15.

Note. When civilian employees of any Federal agency being treated in an Army MTF outside the U.S. will be evacuated to the U.S., the appropriate civilian personnel officer of the agency concerned will be notified.

3-17. Department of Interior civilian employees stationed in American Samoa and their family members

Upon request of the Governor of American Samoa, the Department of Interior civilian employees stationed in American Samoa and their family members may be provided care at Tripler Army Medical Center (TAMC). Charges will be as specified in appendix B for care furnished in the U.S.

Section VI Foreign Nationals

3-18. Care provided in the United States

Care is authorized at Army MTFs in the U.S. for the categories of foreign nationals listed in a below, subject to the charges cited in appendix B. Foreign nationals and family members must present approved identification or ITOs as appropriate when requesting care. Treatment of foreign nationals and their family members are subject to the provisions of approved international agreements. Foreign personnel subject to NATO SOFA or countries under the Partnership For Peace SOFA, their dependents and civilian personnel accompanying the forces may receive medical and dental care, including hospitalization, under the same conditions as comparable personnel of the receiving state. See appendix B for charges.

a. NATO personnel as follows.

(1) Military personnel and their authorized family members of the NATO nations listed in (a) through (n) below are authorized care when stationed in or passing through the U.S. in connection with their official duties. Authorized family members are the spouse and legitimate children, including adopted and step-children, who meet the dependency criteria that apply to U.S. military family members.

- (a) Belgium.
- (b) Canada.
- (c) Denmark.
- (d) Turkey.
- (e) Germany.
- (f) Greece.
- (g) Italy.
- (h) Luxembourg.
- (i) Netherlands.
- (j) Norway.
- (k) Portugal.
- (l) Spain.
- (m) United Kingdom.

(n) France.

(2) Contact the Commander, USAMEDCOM, MCHO-CL-P, 2050 Worth Road, Fort Sam Houston, TX 78234-6010 for a current list of countries under Partnership For Peace SOFA.

(3) Eligible civilians accompanying military personnel in (1) above as employees of an armed service of the nation concerned and their family members may be furnished care at remote installations where civilian medical care is unavailable. At other MTFs, only emergency care may be provided. To be eligible, such civilians cannot be stateless persons, nationals of non-NATO States, U.S. nationals, or residents in the U.S.

(4) The medical portion of the NATO SOFA, as revised by the DOD Appropriations Act, is implemented by (1) and (2) above insofar as care in Army MTFs is concerned.

b. Military personnel whose names appear on the Diplomatic List (Blue List) or the List of Employees of Diplomatic Missions (White List) published periodically by the Department of State and their family members.

c. Military personnel assigned or attached to U.S. military units for duty and their family members.

d. International students assigned or attached to U.S. military units for training and their authorized family members as follows:

(1) International military education training (IMET) trainees, both military and civilian, and the authorized family members of military trainees.

(2) Foreign military sales (FMS) trainees-both military and civilian-and the authorized family members of the military trainees.

(3) Other international trainees (military only) and their family members.

e. Military personnel on duty in the U.S. at the invitation of or with the agreement of the DOD or one of the military Services and their family members.

f. Military personnel accredited to joint U.S. defense boards or commissions and their family members.

g. Emergency care only for IMET trainees in the U.S. on IMET orientation tours. If hospitalized, the IMET rate will apply and will be collected locally from the individual.

h. Other foreign nationals not listed above seeking care in Army MTFs in the U.S. Such persons should be advised to apply for determination of eligibility to Headquarters, Department of the Army (HQDA) (DAMI-FL), Washington, DC 20310-1040, through their country's military attache stationed in Washington, DC.

3-19. Notification of hospitalization in the United States

When international students listed in paragraph 3-18d are hospitalized in Army MTFs in the U.S., notifications specified in a through c below are required. (Notifications required by this para are exempt from reports control under AR 335-15.)

a. *International students.* When international students (para 3-18d) are admitted to an Army MTF, message notification will be dispatched to HQDA (SAUS-IA-SA), Washington, DC 20310-0120. AR 12-15 contains additional notification requirements when a foreign student cannot qualify for training because of physical or mental disability or whose hospitalization or disability will prevent continuation of training for a period in excess of 90 days. Authority for return of students to their home country will be furnished the MTF by HQDA (SAUS-IA-SA).

b. *Nonstudent foreign nationals.* When a foreign national other than a student is admitted to an Army MTF in the U.S., HQDA (DAMI-FL), Washington, DC 20310-1040 will be notified immediately so that the country concerned may be advised of the patient's status. The notification will be forwarded by letter (original and two copies). A copy will also be furnished the Commander, USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Fort Sam Houston, TX 78234-6010. The notification will include the patient's name, nationality, status (military, civilian, family member), and date of hospitalization. It will also include diagnosis, prognosis, and probable date of release. If military, the patient's Service number and branch of Service will be included. If the probable date of release cannot be determined during the initial evaluation, or the notification does not indicate a prolonged period of hospitalization and the patient later requires prolonged hospitalization, further notification will be furnished with this information.

c. *Canadian military personnel.* In addition to the above notifications to HQDA (DAMI-FL), Washington, DC 20310-1040, a copy or extract of the admission and disposition (AAD) report pertaining to Canadian military personnel will be sent immediately to the Canadian Joint Staff, 2450 Massachusetts Ave., NW, Washington, DC 20008.

3-20. Care provided outside the United States

Care is authorized at Army MTFs outside the U.S. for the following categories:

a. Those who provide direct services to the U.S. Armed Forces (para 3-48).

b. IMET trainees and FMS trainees (military and civilian) and the authorized family members of IMET and FMS military trainees.

c. Persons covered by a formal agreement entered into by a Federal agency when care in Army MTFs is a condition of the agreement. (A copy of all such agreements will be sent to Commander, USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Fort Sam Houston, TX 78234-6010.)

d. Liaison officers from a NATO Armed Force or members of a liaison detachment from such a Force. This implements the medical portion of NATO STANAG 2101.

e. Crew and passengers of visiting military aircraft of NATO nations that land at U.S. military or allied airfields. This implements the medical portions of NATO STANAG 3113.

f. Special foreign nationals. Generally, care will be restricted to foreign officials of high national prominence. However, other foreign nationals may be furnished care when unusual circumstances or the extraordinary nature of the case warrant such consideration. Medical care for this category of patient is coordinated by the State Department in conjunction with DOD.

(1) Care may be provided when such action is expected to contribute to the advancement of U.S. public interests. Authority to make determinations regarding the propriety of providing care is vested in commanders of unified and major Army commands (MACOMs) in overseas areas. When geographical dispersion and varying political conditions dictate, authority may be delegated to senior subordinate commanders. Such authority may not be redelegated by these commanders. Normally, the recommendation of the chief of the diplomatic mission of the patient's country will be sought in determining whether care should be provided.

(2) Foreign nationals accepted for care will not be evacuated for care in CONUS Army MTFs except under unusual circumstances as determined by the Secretary of the Army. The U.S. Army attache in the country concerned will coordinate through diplomatic channels.

g. NATO and non-NATO personnel OCONUS. Upon approval from the MTF commander, AD officer and enlisted personnel of NATO and non-NATO countries (and their accompanying dependents living with the sponsor) when serving OCONUS and outside their own country can receive-upon approval from the MTF commander-outpatient care only on a reimbursable basis. Such persons are under the sponsorship of a military service or the major overseas commander has determined that the granting of such care is in the best interests of the U.S. Additionally, such personnel are connected with, or their activities are related to, the performance of functions of the U.S. military establishment.

h. Requests for care by foreign nationals in overseas areas will be forwarded from/through the RMC through Commander, USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Fort Sam Houston, TX 78234-6010 to the Secretary of the Army. The MTF commander will include a recommendation indicating the rate to be charged or if charges will be waived.

3-21. Charges for and extent of care

a. Except as indicated in *b* below, all inpatient care at MTFs in the U.S. will be subject to full reimbursement. Exceptions to this rule will apply only when a reciprocal health care agreement has been negotiated between the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)) and the foreign government concerned, setting forth specific terms under which care will be provided. Commanders will be advised immediately when new agreements are negotiated. Meanwhile, orders or other documents presented by foreign military personnel reflecting eligibility for non-reimbursable inpatient care in MTFs in the U.S. are invalid. With the exception of IMET students, foreign military and diplomatic personnel and members of their families will be charged the full reimbursable rate for inpatient care received in Army MTFs in the U.S. This includes NATO personnel and their families. Charges for IMET personnel will be at the special IMET rates prescribed for inpatient and outpatient care. Charges for outpatient care in the U.S. will be at the rate stated in appendix B for specific categories of foreign nationals. Charges for care outside the U.S. are as stated in appendix B. (Also see DOD Instruction (DODI) 6015.23.)

b. Extent of care and collection procedures are stated in appendix B. The following special provisions apply.

(1) Persons covered under a specific international agreement (para 3-20c) will be provided care to the extent specified in the agreement. If not specified, care will be provided subject to the limitation indicated in (4) below. Such persons will be charged at the rate specified in the agreement or, if no rate is stated, at the inpatient or outpatient rate applicable to the specific category (military or civilian).

(2) NATO liaison personnel (para 3-20d) will be provided care in Army MTFs outside the U.S. under the same conditions and to the same extent as U.S. Army personnel.

(3) Crew and passengers of visiting military aircraft of NATO nations (para 3-20e) will be furnished care available at the airfield concerned. No charge will be made for outpatient care. Subsistence charges incident to hospitalization will be collected locally from the patient. The hospitalization charge stated in appendix B, minus the subsistence portion, will be collected from the appropriate nation by Headquarters, U.S. Army, Europe (USAREUR) upon receipt of DD Form 7 (Report of Treatment Furnished Pay Patients: Hospitalization Furnished (Part A)) or by the OCONUS MEDDAC/MEDCEN (for outside USAREUR) furnishing the care. DD Form 7 is available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web (<http://www.usapa.army.mil/>). Instructions for the use of DD Form 7 are—

(a) Enter the report control symbol (RCS).

(b) Section 1. Name of medical activity, base and/or post, and MACOM, as applicable, providing medical care in CONUS. Enter name of medical activity, Army Post Office (APO), and MACOM OCONUS.

(c) Section 2. Month and year of service covered by the report.

- (d) Section 3. Patient category.
- (e) Section 4. Authority for treatment. If a written authorization is required before treatment, submit a copy of the authorization with DD Form 7. For beneficiaries of the OWCP, submit two copies of DOL Form CA-16 (Authorization for Examination and/or Treatment) with DD Form 7.
- (f) Section 5. Name in full and ID number of each patient. Include the social security claim number if applicable.
- (g) Section 6. Grade or status of individual (that is, civilian, eligible family member, title of seaman, etc.).
- (h) Section 7. Organization. As applicable, unless other information is required for the category of patient concerned.
- (i) Section 8. Diagnosis and diagnosis related group (DRG) of each patient.
- (j) Section 9. Admission date. Day, month, and year of admission to hospital.
- (k) Section 10. Discharge date. Enter the day, month, and year each patient was discharged from the hospital or, if remaining in the hospital at the end of the month, enter the last day of the month followed by the notation "REM" (remaining). A patient on any authorized or unauthorized absence from the hospital for more than 24 hours is reported as discharged from the hospital on the date of departure (the day of departure is not counted as a day of hospitalization).
- (l) Section 11. Total. Enter the total days each patient was hospitalized during the report period. Day of admission is included but not the day of discharge.
- (m) Section 12. Enter date of certification.
- (n) Section 13. Signature of the MTF commander or authorized representative (on the original only) including grade and organization.
- (o) Section 14. Show total days hospitalized and total amount. Item 11 shall equal the total reported in item 14.
- (p) Patients attached for meal days only. Transient patients, casuals, enlisted outpatients attached for meal days only, and duty personnel (other than Air Force, Army, Navy, and Marine Corps) who are entitled to subsistence at Government expense. Submit DD Form 7 in two copies. Complete items 1 through 4. Omit items 5 through 8. In item 9, "Admission Date," indicate the date meal days were provided. Omit item 10. In item 11, enter the total number of meal days served.
- (4) Foreign nationals (para 3-18) will not be admitted to Army MTFs for chronic conditions that would require more than 90 days hospitalization.
- (5) Special foreign nationals (para 3-20f) will be billed locally at the full reimbursable rate unless the approving overseas commander waives charges.
- (6) IMET military and civilian trainees and family members of military trainees (para 3-20b) will be billed locally for subsistence only. At the end of each calendar month, all inpatient and outpatient care furnished IMET trainees in an Army MTF (except in USAREUR) will be reported to Commander, USAMEDCOM, ATTN: MCRM, 2050 Worth Road, Fort Sam Houston, TX 78234-6000 for billing purposes. Billing will be at the proper IMET rate less the amount collected for subsistence. Copies of the ITO will accompany the reports.

Section VII

Beneficiaries of Other Federal Agencies

3-22. General

This section covers the eligibility of beneficiaries of other Federal agencies for care in Army MTFs on a reimbursable basis at the expense of the referring agency under authority of the Economy Act (31 USC 1535). Paragraphs of this section give detailed instructions with regard to the eligibility of beneficiaries of those particular Federal agencies that have made arrangements with the Army for care of such individuals on a relatively permanent, continuing basis. Federal agencies not covered in this section may request care for their beneficiaries in Army MTFs on a reimbursable basis under the Economy Act. Commanders of Army MTFs are authorized to honor such requests within the capability of their MTF to do so without detriment to medical care for persons entitled to care in Army MTFs. Reimbursement for care furnished in response to these individual requests will be at the rates designated in appendix B and obtained locally from the agency requesting or authorizing care. See appendix B of this regulation, DOD 7000.14-R, Volumes 1, 4, and 11, and Defense Finance and Accounting Service (DFAS)-IN Regulation 37-1 for additional accounting guidance.

3-23. Beneficiaries of the Department of Veterans Affairs

- a. Medical care is authorized subject to the conditions specified below.

(1) *VA hospitals/clinics.* Control of all referrals of veterans to Army MTFs, except those in foreign countries as stated in (6) below, is vested in the VA hospital/clinic having jurisdiction over the geographic area in which the Army MTF is located (referred to below as "field station"). The procedures relating to inpatient care apply to routine or emergency admissions to Army MTFs where beds have been allocated for VA patients by prior agreement, as well as emergency admissions to Army MTFs in which bed allocations have not been granted. Admission to an Army MTF

within CONUS in which bed allocations have not been made will be authorized only for the purpose of furnishing emergency medical care.

(2) *Authorization.* Army MTFs will furnish medical care to a veteran on the basis of an authorization for treatment from the field station having jurisdiction. Reimbursement will not be made by the VA for medical care furnished prior to the effective date of the authorization, except as indicated in (3) below.

(3) *Emergency medical care.*

(a) An MTF admitting a veteran for emergency medical care will notify the appropriate field station within 72 hours after the date and hour of admission and request authorization. When the field station authorizes emergency hospitalization, the effective date of the authorization will be the date the patient was admitted to the MTF.

(b) An MTF furnishing emergency outpatient care to a veteran will notify the VA hospital/clinic having jurisdiction within 72 hours after the care was furnished and request authorization. Emergency outpatient care will be authorized by the VA hospital/clinic when necessary in the treatment of a disease or injury incurred or aggravated in active military Service. For a veteran undergoing authorized vocational rehabilitation or education, outpatient treatment is authorized to prevent interruption of training.

(c) When the field station does not authorize the emergency medical care, or when authorization for such care has not been received from that office by the Army MTF while the veteran is receiving medical care, charges for medical care will be collected locally from the veteran concerned.

(4) *Outpatient care.* Outpatient care, other than emergency outpatient care, must be authorized in advance. Such care will be furnished on authorization from the VA hospital/clinic having jurisdiction. When a VA beneficiary is furnished a prosthetic appliance, spectacles, a hearing aid, or orthopedic footwear on an outpatient basis, a separate charge will be made for the item. DD Form 7A (Report of Treatment Furnished Pay Patients: Outpatient Treatment Furnished (Part B)) or The Uniform Bill (UB)-92 (Uniform Bill) will be submitted to the authorizing VA hospital/clinic for reimbursement and will document the type of item furnished and the cost. Charges for spectacles will be according to AR 40-63/NAVMEDCOMINST 6810.1/AFR 167-3. DD Form 7A is available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web (<http://www.usapa.army.mil/>). Instructions for the completion of DD Form 7A are—

(a) Block 1. Name of medical facility, base and/or post, and MACOM, as applicable, providing care in CONUS. Enter unit number, APO, and MACOM, if facility is OCONUS.

(b) Block 2. Month and year of service covered by the report.

(c) Block 3. Patient category.

(d) Block 4. Authority for treatment.

(e) Block 5. Full name and ID number (if any) of each patient.

(f) Block 6. Grade or status of individual, that is, civilian, eligible family member, title of seaman, etc.

(g) Block 7. Organization or other similar information required for category of patient concerned.

(h) Block 8. Diagnosis for each patient. List the diagnosis, physical examination, immunization, and any vaccinations.

(i) Block 9. Dates. List day, month, and year for each medical or dental outpatient visit furnished.

(j) Block 10. Number of outpatient visits and corresponding dollar amount during the month for each patient.

(k) Block 11. Date of certification of report. Enter date of certification.

(l) Block 12. Signature of the MTF commander or authorized representative (on original only), showing grade and organization.

(m) Block 13. Total visits and/or total dollar amount. Enter total outpatient visits and/or total dollar amounts for all patients listed. Double check this figure to make sure that the addition is correct. The sum of the outpatient visits reported in block 10 shall equal the grand total in block 13.

(5) *Disposition of emergencies.* A veteran admitted for emergency medical care will be released from the Army MTF promptly upon termination of the emergency unless another disposition as indicated in (a) and (b) below has been arranged with the field station.

(a) Transfer to a VA treatment facility if further hospitalization is required.

(b) Retention as a VA beneficiary chargeable against a bed allocated to that agency.

(6) *Medical care at Army MTFs in foreign countries.* Care will be authorized by the VA for eligible veterans in need of treatment for Service-connected conditions. The responsibility for authorizing care to veterans in foreign countries is vested in the following agencies:

(a) For veterans in the Trust Territory of the Pacific (Micronesia), the VA Regional Office (VARO), Honolulu, Hawaii.

(b) For veterans in the Philippines, the VARO, Manila, Philippines.

(c) For veterans in Canada, the Canadian Department of Veterans Affairs, Ottawa, Canada.

(d) For veterans in all other foreign countries, the U.S. Consulate Office or the U.S. Embassy.

(7) *Authorization for treatment.* Veterans may be furnished medical care at Army MTFs in foreign countries on presentation of an authorization for treatment. An MTF furnishing a veteran emergency medical care without proper authorization will notify the responsible VA representative, as indicated in (6)(a) through (d) above, within 72 hours

after the date and hour the initial care was rendered. Notification will be by the most expeditious means available and will state the diagnosis and extent of required treatment. It will also request authorization for the treatment and instructions as to the disposition of the patient upon termination of the emergency. If the approving authority does not issue an authorization for this care, charges for medical care will be collected locally from the veteran concerned.

(8) *Wheelchairs and beds.* These items may be furnished without charge, if locally available from Government stocks, to a VA beneficiary upon his or her discharge from the MTF if, in the opinion of the MTF commander, he or she requires constant and continuous use of these items after his or her discharge.

b. The records in (1) and (2) below that are required by the VA are in addition to those required on all patients in an Army MTF. VA Form 10-10 (Application for Medical Benefits), VA Form 10-10M (Medical Certificate and History), SF 502 (Medical Record-Narrative Summary), or DD Form 2770 (Abbreviated Medical Record) will be completed and forwarded to such station. Completion instructions for the VA Form 10-10M and SF 502 (or DD Form 2770) include—

(1) *VA Form 10-10M.* This form will be completed for those veterans who are admitted to any Army MTF for emergency medical care without prior authorization. All information required in the medical certificate will be furnished whether the admission is approved or disapproved by the field station. Since completion of the medical certificate will require examination of the patient, those admissions to the MTF that are disapproved by the field station will be billed to the patient.

(2) *SF 502 or DD Form 2770.* SF 502 or DD Form 2770, as appropriate, will be completed when a veteran is discharged or transferred. When an interim report of hospitalization is requested by the field station, it may be prepared on SF 502.

3-24. Beneficiaries of the Office of Workers' Compensation Programs

The OWCP reimburses health care providers/practitioners for care furnished bonafide beneficiaries under conditions cited below. The Federal agency employing the patient is ultimately rebilled by OWCP for the amount of the reimbursement plus an administrative surcharge. Therefore, all OWCP care in Army MTFs provided to DA civilian employees for OWCP conditions will be provided at no charge. Within DA MTFs, OWCP will be billed only for care furnished civilian employees of other Federal agencies outside DOD. There will be no charge for occupational health. (See para 3-15.) Other Federal agencies outside DOD are billed at the interagency rate for OWCP care provided their employees. OWCP claims documentation will be completed for all patients. For record purposes and for potential compensation claims arising from the injury or illness, claims documentation will be completed at the time care is rendered regardless of the patient's employing agency. The completed documents will be sent to the personnel office of the employing agency. When treatment is required for other than minor injury or illness that is not the result of employment, the patient will be referred to his or her civilian physician after initial emergency treatment. In accidents where the patient is covered by worker's compensation and has military eligibility, the employer will become the primary sponsor and military eligibility will be secondary. The employer will be billed rates as designated in appendix B.

a. *For whom authorized.* Persons in the categories listed below are authorized medical care as beneficiaries of the OWCP.

(1) ROTC members of the Army, Navy, and Air Force provided the condition necessitating treatment was incurred in LD under one of the following circumstances:

(a) While performing authorized travel to or from camps or cruises.

(b) While engaged in a flight or in flight instruction under 10 USC chapter 103. See 5 USC 8140.

(c) During attendance at training camps or while on cruises. The care furnished under this authority relates solely to care furnished after termination of training camps or cruises. For conditions under which care is furnished during the period of attendance at ROTC training camps, see paragraph 3-4.

(2) Civil officers or employees in any branch of the U.S. Government, including an officer or employee of an instrumentality wholly owned by the U.S., who sustain a job-related injury. A job-related injury includes injuries sustained while in the performance of duty and diseases proximately caused by the conditions of employment.

(3) Employees of the Government of the District of Columbia (except certain members of the police and fire departments under the provisions of 5 USC 8101) for injury or disease that is the proximate result of their employment.

(4) Volunteer civilian members of the Civil Air Patrol (CAP) (except CAP cadets under 18 years of age) for injury or disease that is the proximate result of active service, and travel to or from such service, rendered in performance or support of operational missions of the CAP under direction and written authorization of the Air Force.

(5) Former Peace Corps volunteers for injury or disease that is the proximate result of their employment. An injury suffered by a volunteer when he is outside the several States and the District of Columbia is deemed proximately caused by his employment, unless the injury or disease is caused by willful misconduct of the volunteer, caused by the volunteer's intention to bring about the injury or death of himself or of another, or proximately caused by the intoxication of the injured volunteer.

(6) Job Corps enrollees after termination of enrollment or other congressionally mandated programs that authorize care in MTFs for injury or disease that is the proximate result of their employment.

(7) Care will be furnished OWCP beneficiaries upon their presentation of DOL Form CA 16, signed by their

supervisor or a HCFA Form 1500 (Health Insurance Claim Form). This form may be obtained from the nearest local Health and Human Services Health Care Financing Administration. The following special provisions apply:

(a) DOL Form CA 16 will be submitted on an individual basis and may not be used to authorize medical care for the same injury when further medical care is needed by an employee. Rather, the MTF will prepare SF 502 as described in b(1)(b) below.

(b) DOL Form CA 16 will include a nine-digit employee identification number (EIN) as well as an eight-digit billing number. The MTF concerned will ensure that the completed form received from the employing agency bears that agency's EIN.

(c) The Department of Labor limits the period for which treatment is authorized by a DOL Form CA 16 to 60 days from the date of issuance. If the attending physician determines that care will exceed 60 days, a request must be submitted through the employing agency to provide additional care. HCFA Form 1500 and SF 1080 (Voucher for Transfer Between Appropriations and/or Funds) will be submitted for reimbursement to the Commander, USAMEDCOM, ATTN: MCRM-F, 2050 Worth Road, Fort Sam Houston, TX 78234-6000.

(8) Use of military medical facilities by nonappropriated fund (NAF) employees is normally limited to initial or emergency treatment only. See AR 215-1, chapter 14, section XV, for additional information on benefits provided to NAF employees who sustain a job-related illness or injury.

b. Medical care for current employees. Medical care will be furnished a current employee as a beneficiary of the OWCP on presentation of DOL CA Form 16 with Part A prepared and signed by the official supervisor of the employee. If emergency medical care is furnished without presentation of this form, the appropriate official will be notified immediately and requested to submit this form within 48 hours. If that official determines that it is inappropriate to prepare DOL CA Form 16 under the regulations issued by the OWCP and notifies the MTF to that effect, charges for medical care will be collected locally from the individual concerned. Supplies of this form, if needed, may be obtained from the appropriate publication center or the appropriate District Office of the OWCP as shown in figure 3-1.

(1) *Hospitalization.*

(a) The employee will present the original and one copy of DOL CA Form 16 to the Army MTF in which medical care is desired. As promptly as possible after the employee has been examined at the MTF, Part B of this form will be completed and signed by the attending medical officer. The original of the completed DOL CA Form 16 will be forwarded immediately to the appropriate office of the OWCP as shown in figure 3-1. The other copy of the completed DOL CA Form 16 will be attached to DD Form 7 as a substantiating document.

(b) If extensive hospitalization is required, a narrative report will be submitted on SF 502 showing the history, physical findings, laboratory findings, and a general abstract of the patient's hospital record. This information should be forwarded to the appropriate office of the OWCP periodically or at the time of discharge if the hospitalization does not exceed 1 month. The report should also show the diagnosis for conditions due to the injury; conditions not due to the injury; and condition on discharge with the opinion as to the degree of physical impairment, if any, from conditions due to the injury.

(2) *Outpatient care.* The employee will present the original DOL CA Form 16 to the Army MTF in which outpatient medical care is desired. As promptly as possible after the employee is examined at the MTF, Part B of DOL CA Form 16 will be executed by the attending medical officer. The completed form will be retained in the files of the MTF as a possible substantiating document for billing purposes.

(3) *Prostheses and appliances and when authorized by the OWCP.*

(a) All necessary prostheses, hearing aids, spectacles, or special orthopedic footwear will be furnished when required in the proper treatment of a case.

(b) All necessary dental care, including prosthetic dental appliances, will be furnished when authorized by the OWCP.

(c) When a beneficiary of the OWCP is furnished a prosthetic appliance, spectacles, a hearing aid, or orthopedic footwear on an outpatient basis, a separate charge will be made for the item. DD Form 7/7A and SF 1080 will be submitted to the Commander, USAMEDCOM, ATTN: MCRM-F, 2050 Worth Road, Fort Sam Houston, TX 78234-6000 for reimbursement and will show the type of item furnished and the cost. Charges for spectacles will be according to AR 40-63/NAVMEDCOMINST 6810.1/AFR 167-3.

(4) *Transfer of beneficiaries.*

(a) *Transfer of patients requiring prolonged treatment.* A beneficiary of the OWCP requiring prolonged treatment will be reported by the facility to the OWCP for removal from the Army MTF as soon as the patient's condition permits. Transfer will be at the expense of the OWCP.

(b) *Transfer when necessary for other purposes.* When transfer is necessary for the proper treatment of the patient, a beneficiary of the OWCP may be transferred from the Army MTF to another MTF (military or civilian). Prior authorization for such transfers will be secured from the OWCP if time permits. In an emergency, a patient may be transferred without prior authorization, but if such action is taken, the OWCP will be notified immediately. Transfer will be at the expense of the OWCP.

(5) *Disallowances by the OWCP.* The OWCP will advise the MTF of any claim that is not compensable because of

a finding that the employee's injury or disease was not incurred in the performance of duty. In that event, the charges for medical care incurred on or after the date of receipt of the notice of disallowance become the personal responsibility of the employee. The MTF will notify the patient of the OWCP's ruling and collect from him or her for any period of hospitalization or other medical costs subsequent to the date of receipt of the notice of disallowance.

c. Medical care for former employees. Examination and/or follow-up treatment will be furnished a former Government employee as a beneficiary of the OWCP upon presentation of a request from the appropriate district OWCP office. A report of examination and/or treatment, DD Form 7/7A, and SF 1080 will be forwarded to the requesting OWCP office for reimbursement. DD Form 7/7A, as appropriate, will be submitted to Commander, USAMEDCOM, ATTN: MCRM-F, 2050 Worth Road, Fort Sam Houston, TX 78234-60010.

3-25. Beneficiaries of the Public Health Service and National Oceanographic and Atmospheric Administration

a. Medical care. Upon presentation of written authorization, PHS beneficiaries may be provided medical care as indicated in (1) through (3) below. If a beneficiary is furnished emergency care without the required authorization, the MTF commander must seek such authorization as soon as possible from the proper authority as indicated below.

(1) *Native Americans and Alaska Natives.* The authorizing Service unit is the Indian Health Service facility which encompasses the geographic area where the Native American patient resides. In addition, the patient must be eligible for contract services as defined in 42 USC 36c.

(a) *Native Americans in CONUS.* Authorization will be prepared and signed by an Indian Health Service unit director or his or her designee.

(b) *Native Americans and Alaska natives in Alaska.* Authorization will be prepared and signed by the Service unit director or his or her designee of an Indian Health Service unit in Alaska.

(2) *Inactive Reserve PHS commissioned officers.* Medical examination and immunizations may be furnished upon presentation of written authorization from the Commissioned Personnel Operations Division, PHS, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857. The authorization will include the nature of and the reason for the service desired and a statement that the individual is entitled to such service at PHS expense. When immunizations are requested in addition to medical examinations, the type of each immunization will be stated specifically. The original of the completed medical examination report will be sent to the authorizing office referred to above as soon as the examination is completed. A copy of the authorizations for medical examinations and immunizations will be sent to the authorizing office together with DD Form 7/7A and SF 1080 for billing purposes. When hospitalization is needed to conduct these examinations, DD Form 7 and SF 1080 will be forwarded to the authorizing office for collection.

(3) *AD noncommissioned officers and crews (Wage Marine) of vessels of the National Ocean Service, National Oceanic and Atmospheric Administration (NOAA).* This care is limited to emergency care or care specifically authorized by the PHS. (Authorization may be obtained or confirmed telephonically.) All care provided will be reported to the Commander, USAMEDCOM, ATTN: MCRM-F, 2050 Worth Road, Fort Sam Houston, TX 78234-6000 for reimbursement on DD Form 7/7A and SF 1080 as indicated in appendix B.

b. Dental care.

(1) Dental care in the U.S., its possessions, and the Commonwealth of Puerto Rico will be limited to emergency care for the relief of pain or acute conditions and dental care requiring hospitalization. Such care will not include the provision of prosthetic dental appliances or permanent restorations.

(2) In overseas areas, dental care is authorized to the extent needed pending the patient's return to the U.S., a U.S. possession, or the Commonwealth of Puerto Rico.

c. Notification. When a PHS or NOAA officer is admitted to an Army hospital, notification will be made to the Beneficiary Medical Program in Rockville, Maryland at 1-800-368-2777.

3-26. Selective Service registrants

Selective Service (SS) registrants, by or under the authority of the Director, SS, will be furnished necessary medical examinations. Hospitalization is authorized when their medical fitness for military service cannot be determined without hospital study. SS registrants who suffer illness are authorized emergency medical care-including emergency hospitalization-as beneficiaries of the SS system.

3-27. Beneficiaries of the Department of State and associated agencies

a. Officers and employees of the agencies in (1) through (9) below, their family members, and applicants for appointment to such agencies are authorized medical care in Army facilities.

- (1) Department of State.
- (2) U.S. Agency for International Development.
- (3) U.S. Information Agency.
- (4) Foreign Agricultural Service, Department of Agriculture.
- (5) Bureau of Public Roads, Department of Commerce.
- (6) Federal Aviation Administration (FAA).

(7) Foreign Claims Settlement Commission.

(8) Drug Enforcement Administration.

(9) Such other agencies as may from time-to-time be included in the medical program of the Department of State.

b. Care outside the U.S. is authorized as specified below.

(1) *Inpatient care.* Authorization for officers and employees will be prepared by the individual's superior officer, or, if there is no superior officer, by the individual himself or herself. The authorization will show the individual's name, the diagnosis, if known, and will state that the individual is a citizen of the U.S. on duty abroad in the employment of one of the agencies, naming the type of service and the place of duty. In the case of family members, authorization will be prepared by the immediate superior officer of the family member's sponsor, or, if there is no immediate superior officer, by the sponsor himself or herself. The authorization will show the family member's name, the diagnosis, if known, and will state that the family member is residing abroad with his or her sponsor. It will also give the name and relationship of the family member's sponsor, with the statement that the sponsor is a citizen of the U.S. abroad in the employment of one of the above agencies, giving the place and type of employment. In either case, the authorization will also state that the individual is entitled to inpatient care at the expense of one of the agencies listed in a(1) through (9) above.

(2) *Outpatient treatment.* Outpatient treatment at the expense of one of the agencies in a(1) through (9) above is authorized only when treatment is furnished for a condition that results in hospitalization or treatment required for post hospitalization follow up.

(3) *Medical examinations and immunizations.* Medical examinations including periodic examinations (usually biennial) and immunizations may be furnished upon presentation of authorization completed as indicated in (1) above. In addition, the authorization will include the nature of the service desired, the justification, and contain the statement that the individual is entitled to these services at the expense of one of the above agencies. Proper medical examination documentation—in triplicate—will be enclosed with the authorization showing in detail the exact extent of the medical examination required. When immunizations are requested, the type of each immunization will be stated specifically. The original and one copy of medical examination documentation will be forwarded, as soon as the examination is completed, to the authorizing office.

(4) *Dental care.* Dental care may be provided on a space-available and reimbursable basis.

(5) *Care not covered by the Department of State medical program—*

(a) *Inpatient care.* Authorization for officers and employees and their family members listed above will be prepared as indicated in b(1) above, except it will state that charges for medical care will be collected from the individual.

(b) *Outpatient treatment.* Charges for all outpatient treatment will be collected locally from the individual.

(c) *Dental care.* Dental care will be limited to that authorized in (4) above.

c. Medical examinations and immunizations of applicants for appointment as officers or employees in the service of one of the agencies in a above may be furnished upon presentation of authorization completed as indicated in b(1) above. For additional instructions concerning authorization and disposition of forms, the provisions of b(3) above apply.

d. Officers and employees and their family members (to include applicants for appointment) who are beneficiaries of one of the agencies in a above are authorized care as follows:

(1) *Medical examinations and immunizations.* Medical examinations and immunizations of applicants for appointment as officers or employees in the service of one of the agencies in a above.

(2) *Periodic medical examinations.* Periodic medical examinations (usually biennial) of officers and employees of one of the agencies in a above who are on duty or leave in CONUS.

(3) *Medical examinations and immunizations.* Medical examinations and immunizations for family members of officers and employees of one of the agencies in a above. Authorization for any of these services will be prepared by one of the agencies in a above as indicated in b(1) and (2) above.

e. Those officers and employees and their family members listed in a and c above who are hospitalized in Army MTFs outside the U.S. and require prolonged hospitalization may be evacuated to the U.S. through medical evacuation channels. Such evacuation, in the case of officers and employees, will be coordinated with the nearest office of the agency concerned.

f. The extent of medical care furnished at Army MTFs in the U.S. and reimbursement criteria prescribed in the case of those officers and employees and their family members listed in a above, who are evacuated to the U.S. for medical reasons, will be comparable in all respects to that which is authorized or prescribed outside the U.S. Officers and employees listed in a above who are returned to the U.S. for non-medical reasons (for example, leave or TDY) and accompanying family members may be furnished medical care at the expense of one of the agencies in a above for treatment of an illness or injury that was incurred in LD while outside the U.S.

g. For the extent of medical care authorized in the U.S. for those officers and employees and their family members listed in b(5) above who are evacuated to the U.S. for medical reasons, the provisions of paragraph 3-54 apply.

3-28. Peace Corps personnel (volunteers, volunteer leaders, and employees), including Peace Corps applicants, and family members of volunteer leaders and employees

Medical care will be furnished subject to the conditions specified below and upon presentation of a signed authorization for treatment from a representative of the Peace Corps in the case of volunteers, volunteer leaders, and family members of volunteer leaders; from a representative of the Department of State (the principal or administrative officer of the Foreign Service Post) in the case of employees and their family members; or from a representative of Peace Corps Headquarters in Washington, DC in the case of Peace Corps applicants.

a. Outside the U.S.

(1) *Volunteers, volunteer leaders, and family members of volunteer leaders.* Medical care is authorized under the same conditions and at the same rate for the same care as personnel listed in paragraph 3-27.

(2) Employees and their family members.

(a) Employees and their family members who are beneficiaries of the Peace Corps are authorized the same care, under the same conditions, and at the same rate as personnel listed in paragraph 3-27.

(b) Employees and their family members who are not beneficiaries of the Peace Corps are authorized the same care under the same conditions and at the same rate as personnel listed in paragraph 3-27b.

(3) Peace Corps applicants.

(a) Except as provided in (b) below, medical services for Peace Corps applicants are limited to medical examinations and immunizations. Hospitalization is authorized only when necessary for the proper conduct of examinations. Reports of medical examinations will be forwarded to Director, Medical Programs, Peace Corps, Washington, DC 20006.

(b) Peace Corps applicants in training status outside the U.S. are authorized medical care in Army MTFs on the same basis as Peace Corps volunteers.

b. Inside the U.S.

(1) *Peace Corps applicants.* Medical service in the U.S. for Peace Corps applicants is limited to medical examinations and immunizations. Hospitalization is authorized only when necessary for the proper conduct of examinations.

(2) *Volunteers, volunteer leaders, and family members of volunteer leaders and employees.* Except as provided in (3) below, medical care is authorized only on a temporary basis (para 3-54).

(3) *Peace Corps volunteers.* Peace Corps volunteers evacuated from stations in the South Pacific may be provided care at TAMC.

c. Records. A complete medical report will be furnished the local Peace Corps physician upon completion of hospitalization or, in the event of a prolonged illness, a medical report will be sent periodically. Similarly, in the case of outpatient treatment, a brief medical report will be forwarded to the local Peace Corps physician upon completion of treatment.

d. Evacuation. Evacuation from an Army MTF to CONUS will be coordinated with the local Peace Corps representative.

e. Care as OWCP beneficiaries. See paragraph 3-24 for care available to Peace Corps volunteers as beneficiaries of the OWCP.

3-29. Members of the U.S. Soldiers' and Airmen's Home

a. Except as provided in b below, members of the U.S. Soldiers' and Airmen's Home (USSAH) are authorized care as beneficiaries of the USSAH. Care is limited to medical facilities at Andrews AFB; Bolling AFB; Forts Belvoir, Meade, Myer, McNair and Detrick; and Walter Reed Army Medical Center. Any charges will be billed to the USSAH for collection from individual residents as appropriate.

b. Members of the USSAH who are also retired members of the Army or Air Force will be treated as retired members under the provisions of paragraph 3-9 and 3-10.

c. Non-retired residents of the USSAH are authorized outpatient care at no cost and inpatient care at subsistence rates billed to the USSAH. On 22 Oct 87, the Assistant Secretary of the Army declared these patients Secretary of the Army designees.

3-30. Beneficiaries of the Department of Justice

a. Federal Bureau of Investigation. Upon presentation of written authorization, agents of the Federal Bureau of Investigation may be furnished medical examinations. Charges for medical examinations will be collected from the Department of Justice on submission of DD Form 7/7A and SF 1080. When hospitalization is necessary for the proper conduct of these examinations, DD Form 7 will be forwarded to the U.S. Department of Justice through the Commander, USAMEDCOM, ATTN: MCRM-F, 2050 Worth Road, Fort Sam Houston, TX 78234-6000.

b. Claims administered by the Department of Justice. Upon presentation of written authorization from the Department of Justice or the U.S. attorney in the case, persons whose claims are being administered by the Department of Justice may be furnished medical examinations to determine the extent and nature of the injuries or disabilities claimed. Charges for medical examinations will be collected locally from the Department of Justice through the Commander, USAMEDCOM, ATTN: MCRM-F, 2050 Worth Road, Fort Sam Houston, TX 78234-6000 on submission of DD Form

7A and SF 1080. When hospitalization is necessary for the proper conduct of these examinations, DD Form 7 will be forwarded to Commander, USAMEDCOM, ATTN: MCRM-F, 2050 Worth Road, Fort Sam Houston, TX 78234-6000.

3-31. Beneficiaries of the Treasury Department

a. Treasury, U.S. Customs agents, and Secret Service agents (examinations). Upon presentation of written authorization, examinations may be conducted and will be recorded in the same manner as routine annual medical examinations for Army officers, but on an outpatient basis only. If hospitalization is considered desirable in connection with the examination, a statement to that effect will be entered in item 42 or 44 of the SF 88 (Report of Medical Examination), as appropriate. One copy of the SF 88 and SF 93 (Medical Record-Report of Medical History) for medical examinations provided these agents will be forwarded to the Chief, U.S. Secret Service, Treasury Department, Washington, DC 20220. Charges for examinations will be collected from the Department of Treasury on submission of DD Form 7A supported by a copy of the authorization for medical examination and SF 1080. AR 1-4 addresses medical support provided the U.S. Secret Service in performing its protective responsibility.

b. Agents of the U.S. Customs Service and their prisoners. U.S. Customs Service agents and prisoners under their jurisdiction may be provided emergency medical care at Army MTFs located near CONUS borders. Services provided will be reported to the Commander, USAMEDCOM, ATTN: MCRM-F, 2050 Worth Road, Fort Sam Houston, TX 78234-6000 on DD Form 7/7A and SF 1080, as appropriate, for reimbursement. The guarding of civilian prisoners in the custody of U.S. Customs Service agents will be provided by the U.S. Customs Service or other appropriate nonmilitary law enforcement agency (para 3-38).

3-32. Federal Aviation Administration air traffic control specialists

a. Upon written request from the FAA regional flight surgeon, Army MTFs are authorized to provide the following ancillary examinations on an outpatient basis to air traffic control specialists who are undergoing a physical examination by an FAA physician:

- (1) Resting electrocardiogram.
- (2) Exercise electrocardiogram.
- (3) Posterior-anterior chest x ray.
- (4) Audiogram.
- (5) Basic blood chemistries listed below (plus automated blood chemistry program, if available. Example: SMA-12.)
 - (a) Two-hour post prandial blood sugar.
 - (b) Blood urea nitrogen.
 - (c) Serum cholesterol.
 - (d) Uric acid.

b. The Army will not read or evaluate the results of tests. Results will be forwarded directly to the FAA regional flight surgeon who requested the examination.

c. Services provided will be reported for reimbursement to the FAA through the Commander, USAMEDCOM, ATTN: MCRM-F, 2050 Worth Road, Fort Sam Houston, TX 78234-6000 on DD Form 7A and SF 1080 supported by a copy of the request from the agency for the Services.

3-33. Job Corps and other Congressionally mandated Volunteer Programs in Service to America and applicants

a. Verification. Before treatment or examination is provided, there must be verification that personnel in the Congressionally mandated program are authorized care or examination at an Army MTF.

b. Job Corps. Job Corps applicants for enrollment and Job Corps enrollees may be provided the services in (1) and (2) below in Army MTFs as beneficiaries of the Department of Labor. An authorization signed by an appropriate Job Corps official must be presented before services can be provided.

(1) Job Corps applicants for enrollment may be provided pre-enrollment medical examinations and immunizations.

(2) Job Corps enrollees may be provided hospitalization, outpatient medical treatment, examinations, and immunizations. Dental care will not be provided except emergency treatment to relieve pain and suffering.

c. Services available at MEPS. The MEPS commander may provide pre-employment medical examinations on a space-available basis.

d. Remediable physical defects. Upon presentation of an appropriate authorization form signed by a Job Corps or Volunteers in Service to America (VISTA) physician, surgery or other treatment required to correct remediable physical defects of Job Corps enrollees and VISTA personnel may be provided. Army MTFs may provide these services if, in the professional judgment of the medical officers concerned, such treatment is indicated and the required sources are available. The authorization form should contain a statement that in the opinion of the authorizing physician, the condition will interfere with or substantially impede the training or future employability of a Job Corps enrollee or will seriously interfere with a VISTA volunteer's performance of duty.

e. Reports to Job Corps. Hospitalization, outpatient care, examinations, and immunizations furnished will be reported for reimbursement to the Job Corps through the Commander, USAMEDCOM, ATTN: MCRM-F, 2050 Worth

Road, Fort Sam Houston, TX 78234-6000 on DD Form 7/7A and SF 1080 supported by documentation from the Job Corps or VISTA authorizing the services. In the case of VISTA personnel provided hospitalization or outpatient treatment on the basis of their Blue Cross and Blue Shield ID card, the VISTA ID number of the patient will be shown after the name of the patient in item 5 of the DD Form 7/7A.

f. Beneficiaries of the OWCP. After termination of their duty with the Job Corps or VISTA, these personnel are eligible for OWCP benefits. To establish their eligibility for these benefits, Army MTFs providing treatment to such personnel will, upon request, complete the medical certificate.

3-34. Social Security beneficiaries

Nonbeneficiaries who are Medicare-eligible may be provided hospitalization in Army MTFs in the U.S. in an emergency to prevent undue suffering or loss of life. The local office of the Social Security Administration (SSA) will be notified as soon as possible after emergency admission of one of their beneficiaries. The SSA can pay for care furnished its beneficiaries in a Federal hospital only if it is located in the U.S. and only during the period of the emergency. The patient or responsible family member will be informed of this and will be advised that arrangements should be made with a civilian hospital that participates in the Medicare Program so that the patient can be transferred as soon as his or her condition has improved to the extent that he or she can be moved. Emergency hospitalization of SSA beneficiaries will be reported for reimbursement to the appropriate financial intermediary on DD Form 7/7A along with a UB-92 (Uniform Bill) or HCFA Form 1450 (Billing Statement). Amounts unpaid by the financial intermediary will be collected from the patient. This paragraph does not apply to family members and retired members and their family members who are beneficiaries under the provisions of sections III and IV of this chapter. UB-92 and HCFA Form 1450 may be obtained from the nearest local Health and Human Services Health Care Financing Administration or accessed on the HCFA.gov web site.

3-35. Micronesian citizens

Pacific Island Nation citizens covered by the Compact of Free Association and referred by their governments to TAMC for specialized treatment may be provided hospitalization and outpatient treatment. Pacific Island governments will be billed at interagency rates or at rates established by the commander of TAMC according to the Compact of Free Association. Because of historical status as Trust Territories of the Pacific Islands, payment guaranteed by governments of Pacific Island Nations will be treated as reimbursement source code 899, "all other Federal agencies outside DOD."

3-36. American Samoan citizens

Citizens of American Samoa referred by the Governor of American Samoa to TAMC for specialized treatment may be provided hospitalization and outpatient treatment as beneficiaries of the government of American Samoa at rates specified in appendix B. Collection will be made locally.

Section VIII

Miscellaneous Categories of Eligible Persons

3-37. Secret Service protectees and protectors

Medical service authorized by AR 1-4 on a nonreimbursable basis includes care in Army MTFs for persons protected by the U.S. Secret Service (for example, the President of the U.S.) and individuals engaged in providing such protection. When hospitalized, a charge for subsistence will be collected locally from the individual.

3-38. Persons in military custody and nonmilitary Federal prisoners

a. Enemy prisoners of war and other detained personnel. Members of the enemy armed forces and other persons captured or detained by U.S. Armed Forces are entitled to medical treatment of the same kind and quality as that provided U.S. Forces in the same area. Detainees suffering from serious injury or disease necessitating special treatment or hospitalization will be medically evacuated to the military or civilian medical unit where such treatment can be given. When civilian hospital facilities are not available, or their use is not feasible because of operational or security considerations, U.S. MTFs will be utilized for the medical treatment of civilian internees or other civilians injured, wounded, diseased, or ill as a result of enemy or allied actions. Ambulatory detainees will be transferred to the nearest detainee collecting point or prisoner of war/civilian internee camp when the need for special medical care has been fulfilled. Other civilians may be released or transferred to the nearest civilian medical facility as the patient's medical condition permits (AR 190-8, AR 190-57, DA Pam 27-1, and the 1949 Geneva Convention, Article 122 and Article 138).

b. Military prisoners.

(1) Military prisoners whose punitive discharges have been executed but whose sentences have not expired are authorized all necessary medical care.

(2) Military prisoners whose punitive discharges have been executed and who require hospitalization beyond expiration of sentences are not eligible for care but may be hospitalized as pay patients until disposition can be made to some other facility.

(3) Military prisoners on parole pending completion of appellate review or whose parole changes to an excess leave status following completion of sentence to confinement while on parole are members of the military services. Accordingly, they are authorized medical care to the same extent as other soldiers. An individual on parole whose punitive discharge has been executed is not a member of the military services and is not eligible for care in Army MTFs. However, in exceptional circumstances, care in Army MTFs may be requested under the provisions of Secretary of the Army designee in paragraph 3-50. (Additional details are contained in AR 190-47.)

c. Nonmilitary Federal prisoners. Such persons are authorized only emergency medical care. When such care is furnished, the institution to which the prisoner is sentenced must furnish the necessary guards to control the prisoner and prevent his or her escape. Under no circumstances will military personnel be utilized to guard or control the prisoner. Upon completion of emergency medical care, arrangements for transfer to a nonmilitary medical facility or return of the prisoner will be made with the appropriate official of the institution to which the prisoner is sentenced. Charges for emergency medical care will be collected from the authorizing institution by submitting DD Form 7/7A and SF 1080.

3-39. Maternity care for former members of the Armed Forces

a. General. Except as provided in e below, former members of the Armed Forces separated with service characterized as honorable or general (under honorable conditions), or described as uncharacterized, who are shown by an examination given at an Armed Forces MTF to have been pregnant at the time of separation are authorized maternity care in MTFs for that pregnancy as specified below. Such care is limited to MTFs having OB/GYN capability. Care in civilian facilities is not authorized at Government expense except when necessary to augment treatment provided at the MTF. This care is provided in the same manner as care for AD soldiers within the MTFs area of responsibility to include providing care under MCS contracts. The term "maternity care" as used here includes prenatal care, hospitalization, and delivery. Newborns will be charged the full reimbursable rate from the time of birth. (See para 3-12c.) (This provision does not apply to RC members who are completing a period of authorized training except when they have served at least one year of continuous extended AD and meet other requirements of this para.) The provisions of this paragraph also apply to former members of the commissioned corps of the PHS and the NOAA and their newborn infants. Charges for care applicable for AD soldiers of the commissioned corps of PHS and NOAA will apply and will be billed to PHS.

b. Application. Eligible former members requesting maternity care will apply in writing to the MTF nearest their home and present a copy of either DD Form 214 (Certificate of Release or Discharge from Active Duty), DD Form 256A (Honorable Discharge Certificate), or DD Form 257A (General Discharge Certificate (Under Honorable Conditions)). They will also present documentation of their pregnancy at the time of separation as proof of eligibility for maternity care.

c. Newborn infants. If the infant is referred to a civilian source, care is at the mother's expense.

d. Abortions. Medical care may include abortions under the conditions outlined in paragraph 2-18.

e. EPTS pregnancies. The provisions of this paragraph do not apply to members who are determined by medical authorities to have been pregnant on the date of entrance on AD or any type of authorized duty.

3-40. Individuals whose military records are being considered for correction

Individuals who require medical evaluation in connection with consideration of their case by the Army, Navy, or Air Force Board for Correction of Military Records are authorized evaluation, including hospitalization when necessary, in Army MTFs. (Army personnel in this category are advised by The Adjutant General that they may report to a designated medical facility for evaluation.)

3-41. Seamen

a. General. Civilian seamen in the service of vessels operated by the DA or the Military Sealift Command listed in b and c below are still in the service of a vessel, although not on board and not engaged in their duties, as long as they are under the power and jurisdiction of competent DA or Military Sealift Command authorities.

b. Civilian seamen in the service of vessels operated by the DA. Such seamen paid from appropriated funds are authorized to receive without charge those occupational health services outlined in AR 40-5. Except in emergencies, such persons will be furnished medical care (other than occupational health services) only when facilities of the PHS are not available. Authorization for such care will be granted upon presentation of written authorization, from the vessel master or other appropriate administrative authority, which may be dispensed only in emergencies.

c. Civilian seamen in the service of vessels operated by the Military Sealift Command. Such persons are eligible for care upon presentation of written authorization from the vessel master or other appropriate administrative authority. When immediate treatment is required and the employee concerned does not have the required written authorization, the nearest Military Sealift Command office or representative will be requested to submit such authorization as soon as possible. The authorization will be attached to DD Form 7/7A and SF 1080 and related documents when submitted to the authorizing military sealift command office for reimbursement.

d. Crews of ships of U.S. registry. Such crews-including ships' officers-are eligible for care when outside the U.S., its territories, possessions, and the Commonwealth of Puerto Rico. This category includes the crews of ships of U.S.

registry such as those aboard DOD time-chartered vessels of commercial operators, those aboard time-chartered vessels referred to above for emergency medical care, and those on privately owned and operated vessels.

e. Care as OWCP beneficiaries. See paragraph 3-24 for care available to civilian seamen as beneficiaries of the OWCP.

Note. Dental care authorized to seamen by this paragraph will be limited to emergency dental care for the relief of pain or acute conditions or for dental conditions requiring hospitalization. Such dental care will not include the provisions of prosthetic dental appliances or permanent restorations.

3-42. Red Cross personnel

a. MTF Commanders, CONUS AND OCONUS, may accept the services of the Red Cross, as well as the services of Red Cross volunteers providing support to Government personnel in the delivery of health care and health care-related services to Armed Forces personnel and DOD beneficiaries. The acceptance of Red Cross services and services of Red Cross volunteers will be in strict compliance with AR 930-5. The MTF Commanders are responsible for ensuring that Red Cross volunteers placed under their supervision conform to the provisions of paragraph b below.

b. Individual Red Cross volunteers providing authorized health care and health care-related services, including physicians, dentists, nurses (practical and registered), pharmacists, therapists, podiatrists, psychologists, and orderlies will—

(1) Be subject to the same control by the MTF supervisor that is exercised over compensated personnel providing comparable services;

(2) Provide those services within the scope of their authorized duties;

(3) Be licensed, credentialed, and privileged according to AR 40-68;

(4) Comply with applicable standards of conduct;

(5) Receive no compensation from any source, including the Red Cross or any agency of the United States, for the services provided; and,

(6) Not perform any policy-making functions.

c. Red Cross volunteers providing health care and health care-related services consistent with the provisions of paragraph b above will be considered employees of the United States for purposes of claims arising from the performance of such services. Consequently, they will be expected to notify the MTF Commander or his or her representative of all actual or potential claims (for example, filed pursuant to the Federal Tort Claims Act or Military Claims Act) and to cooperate fully with the United States in its investigation.

d. When on a tour of duty with a Uniformed Service outside the U.S., Red Cross personnel and their family members, are authorized hospitalization and medical care on a space-available basis. Charges for care will be at the subsistence rate and collected locally from the patient. At MTFs in the U.S., authorization is limited to treatment of injuries sustained in the performance of duties at an Army installation.

3-43. Civilian student employees

a. As used in this paragraph, “civilian student employee” applies to a student nurse, medical or dental intern, resident-in-training, student dietitian, student physical therapist, student occupational therapist, and any other student employee assigned to an Army MTF for training purposes under an affiliation agreement with a civilian institution (AR 351-3).

b. Civilian student employees are authorized care as OWCP beneficiaries for injury or disease that is the proximate result of their employment (para 3-24a(2)).

c. Such employees are also authorized occupational health services as described in AR 40-5.

d. Medical care for other conditions occurring during the training period may be authorized at the discretion of the MTF commander. Such care will not include elective medical treatment or treatment for prolonged periods.

e. Treatment authorized by c and d above will be without charge except for subsistence when hospitalized.

3-44. Civilian employees of U.S. Government contractors and their family members outside the United States

These employees and their family members may be provided care only outside the U.S. except as provided in paragraph 3-45.

3-45. Medical examinations for civilian employees of DOD contractors

Civilian employees of DOD contractors listed in a, b, c, and d below are authorized medical examinations at Army MTFs both within and outside the U.S. When hospitalization is necessary for the proper conduct of the examination, a charge for subsistence will be collected locally from the individual.

a. Civilian contractor flight instructors.

b. Civilian contractor employees upon request of the Defense Logistics Agency under the DOD Industrial Security Program (AR 380-49).

c. Civilian employees of food service contractors (AR 40-5).

d. Civilian employees of DOD contractors on a reimbursable basis (app B) working with nuclear and chemical surety programs according to AR 50-5 and AR 50-6.

3-46. Civilian participants in Army-sponsored activities

Civilian participants in Army-sponsored sports, recreational, educational, or training activities who are injured or become ill while participating in such activities may be furnished inpatient and outpatient medical care without charge except for subsistence when hospitalized. The commander of an MTF may also furnish medical examinations and immunizations to these individuals when he or she considers that such procedures are necessary. Hospitalization will be furnished only on a temporary basis until such time as appropriate disposition can be accomplished. Persons eligible under this paragraph include but are not limited to—

- a. Senior ROTC cadets and students participating in extracurricular activities under Army sponsorship.
- b. Junior ROTC students participating in Army-sponsored instructional activities.
- c. Boy Scouts and Girl Scouts of America participating in visits, training exercises, and encampments at Army installations.
- d. Civilian athletes training and/or competing in sports activities as part of the U.S. Olympic effort.
- e. Civilian participants in Army marksmanship and parachute team training and competitive meets.
- f. Students and members of sports groups invited to participate in sports activities at Army installations as part of the Army Sports Program.
- g. Members of little league teams participating in sports, recreational, or training activities at Army installations.

3-47. Claimants whose claims are administered by Federal departments and claimants who are the proposed beneficiaries of private relief bills

a. *DOD.* To determine the extent and nature of the injuries or disabilities claimed, civilian claimants, upon the request of the agency responsible for administering the claim, may be furnished medical examinations and hospitalization incident thereto, including subsistence, without incurring any charge.

b. *Other Federal departments.* To determine the extent and nature of the injuries or disabilities claimed, civilian claimants upon the request of the Federal department responsible for administering the claim may be furnished medical examinations-including hospitalization-when necessary for the proper conduct of the examination. When hospitalization is necessary for the proper conduct of these examinations, DD Form 7/7A and SF 1080 will be forwarded to the authorizing department for reimbursement.

c. *Other claimants.* Claimants who are the proposed beneficiaries of private relief bills based on injuries or disabilities allegedly arising out of the operation of the DOD may be furnished medical examinations and hospitalization incident thereto, including subsistence, without any charge in order to determine the extent or nature of the injuries or disabilities claimed.

3-48. Persons who provide direct services to the U.S. Armed Forces outside the United States

a. Emergency medical care may be provided in Army MTFs in overseas areas for persons listed in b through d below when they are in the overseas area under ITOs from the DOD or one of the military departments. Care will be provided on a space-available basis. Medical care is not authorized during delays en route except when such delays are for the convenience of the DOD or the Department of State.

b. The categories listed below will be provided emergency outpatient care without charge. Charges for hospitalization will be as stated for each category.

- (1) Civilian religious leaders or religious groups.
- (2) Athletic consultants or instructors.
- (3) Representatives of the United Service Organization (USO) except those listed in c below.
- (4) Representatives of other social agencies and educational institutions.
- (5) Persons in similar status who provide direct services to the Armed Forces.

c. USO professional personnel and accompanying family members may be furnished care at overseas MTFs on a space-available, reimbursable basis. Patients in this category will be required to present proper USO identification. Charges for care will be billed to local USO center headquarters at the full reimbursement rate.

d. Educational representatives of recognized educational institutions regularly assigned to duty in overseas areas, who are providing direct services to the U.S. Armed Forces, and their family members when residing with their sponsors, may be furnished medical care at rates prescribed in appendix B.

3-49. American nationals

American nationals outside the U.S. covered by agreements between the DA and their Federal civilian agencies may be furnished medical care when care in Army MTFs is a condition of the agreement.

3-50. Designees of the Secretary of the Army

- a. Persons not otherwise eligible for medical care may receive such care when they are designated for this purpose

by the Secretary of the Army. Charges are determined on a case-by-case basis by the approving authority. Requests should be initiated through the MTF patient administration division (PAD) and be submitted to Commander, USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Fort Sam Houston, TX 78234-6010 following the format in the sample memorandum at figure 3-2.

b. Each Uniformed Service secretary has a designee program. Requests should be initiated by the applicant through the uniform services MTF where he or she is seeking care.

c. Non-AD chaplains who are employed in the full-time provision of religious support to the U.S. Military Academy, West Point and their family members are authorized medical and dental care at Army MTFs at Government expense, except for subsistence, at the same level authorized for uniformed members and their family members.

d. Certain civilian officials within the Government are provided Secretary of Army designee status for medical and emergency dental care within CONUS. Charges will be at the "others rate." Within the National Capital Region (NCR), charges for the outpatient care provided all designated officials are waived. Charges for the inpatient care provided members of Congress inside and outside the NCR will be the "full reimbursement rate." Charges for other designated officials for inpatient care inside the NCR and for inpatient and/or outpatient care provided outside the NCR will be at the "interagency rate." Officials provided Secretary of Army designee status include—

- (1) The President.
- (2) The Vice President.
- (3) Cabinet members.
- (4) Article III Federal judges (active and retired).
- (5) U.S. Court of Military Appeals judges.
- (6) Congressmen or Congresswomen.
- (7) Secretary and Deputy Secretary of Defense.
- (8) Under Secretary of Defense for Policy.
- (9) Under Secretary of Defense Acquisition.
- (10) Director of Defense Research and Engineering.
- (11) Assistant Secretaries of Defense.
- (12) Comptroller of the DOD.
- (13) General Counsel of the DOD.
- (14) Inspector General of the DOD.
- (15) Director of Operational Test and Evaluation for the DOD.
- (16) Assistant to the Secretary of Defense for Atomic Energy.
- (17) The Secretaries, the Under Secretaries, and the Assistant Secretaries of the Military Departments.
- (18) The General Counsel of the Military Departments.

e. The Secretary of the Army has delegated the granting of Secretarial designee authority to the MTF commander for newborn infants of former soldiers and newborn infants of dependent daughters of AD born in Army MTFs. The extent of this care applies to the initial hospitalization and one well-baby check only, and the designee will be subject to the same charges as would apply to any dependent entitled to medical care.

3-51. Preadoptive children and court appointed wards

The Secretary of the Army has authorized pre-adoptive children of AD and retired members of the Uniformed Services to receive medical care in Army MTFs until the adoption is finalized and they become entitled to care under 10 USC 1072. Care will be provided under the same conditions and subject to the same charges as would apply to any family member. (See para 3-11.) Court appointed wards are entitled to care as specified in paragraph 3-11 and become TRICARE eligible beneficiaries effective on the date appointed as a ward by the court.

3-52. Family members of certain members sentenced, discharged, or dismissed from the Uniformed Services

Health care is authorized in MTFs and under the TRICARE Program for family members of former military members under the following conditions.

a. The member has received a dishonorable or bad-conduct discharge or was dismissed from a Uniformed Service as a result of a court-martial conviction for an offense, under either military or civilian law, involving abuse of a dependent of the member or was administratively discharged from a Uniformed Service as result of such an offense.

b. Family members of soldiers who receive a dishonorable or bad-conduct discharge or a court-martial conviction for an offense involving abuse are authorized 1 year of medical and dental care for injury or illnesses resulting from the abuse or for an adverse health condition resulting from knowledge of the abuse. This care is granted through the Secretary of the Army Designee Program. Care in MTFs will be subject to the availability of space and capability of the professional staff. Care shall terminate 1 year from the date of the sponsor's discharge or dismissal. Request for medical care under this provision should be forwarded to the address in paragraph 3-50a to include information

indicated in figure 3-2, paragraphs 4a through 4h. AR 608-1 (Army Community Services Program) outlines eligibility for medical and other benefits under this program.

3-53. Ineligible persons outside the United States

In special circumstances, a major overseas commander (para 1-4b) may authorize care for an ineligible person in Army MTFs under his or her jurisdiction when he or she considers this to be in the best interest of his or her command. Charges for care provided under this paragraph will be at the full reimbursable rate and collection will be made locally.

3-54. Certain personnel evacuated from one area to another

Personnel may be evacuated for medical reasons from an area in which they are eligible for medical care to an area where they are not otherwise eligible for such care. In these cases, personnel will be admitted to or furnished treatment at Army MTFs to which evacuated or while en route thereto when medical care is deemed necessary. Care should be furnished under this paragraph on a temporary basis only until such time as appropriate disposition can be accomplished. When transferring Secretarial designees of one Service to another, prior approval should be acquired from the Office of the Secretary of the Service of the gaining MTF.

3-55. Civilians in emergency

Any person is authorized care in an emergency to prevent undue suffering or loss of life. Civilian emergency patients not authorized Army MTF services will be treated only during the period of the emergency. Action will be taken to transfer such patients as soon as the emergency period ends. Charges for medical care under this paragraph will be at the full reimbursable rate.

3-56. Volunteer subjects in approved Department of the Army research projects

Volunteers under the provisions of AR 40-38 and AR 70-25 are authorized necessary medical care for injury or disease that is the proximate result of their participation in clinical investigation or research protocols. Medical care charges for all categories of personnel described in this chapter will be waived when they require care which is the proximate result of participation in clinical investigation or research protocols. Medical care for civilian employees who volunteer and who perform duty as a volunteer during their regularly scheduled tour of duty will be provided according to paragraph 3-24.

3-57. U.S. nationals in foreign penal institutions

U.S. nationals serving with, employed by, or accompanying the Armed Forces outside the U.S. and its possessions, and their family members, when confined in foreign penal institutions, are authorized medical care of the type and quality furnished prisoners in U.S. military confinement (AR 27-50).

3-58. Domestic servants outside the United States

Army MTFs located outside the U.S. are authorized to provide the following with charges as indicated in appendix B for domestic servants employed or to be employed by DOD military and civilian personnel:

- a. Preemployment health examinations.
- b. Periodic communicable disease detection examinations.
- c. Immunizations.

3-59. U.S. contractor civilian employees stationed in American Samoa

Upon request of the Governor of American Samoa, U.S. contractor civilian employees stationed in American Samoa may be provided care at TAMC. Charges will be collected locally from the individual at rates prescribed in appendix B.

3-60. Civilians injured in alleged felonious assaults on Army installations

When required to complete a criminal investigation, the Secretary of the Army has given commanders of Army MTFs discretionary authority to provide examination and initial treatment without charge to a civilian injured in an alleged felonious assault (for example, alleged rape) occurring on an Army installation. There is no authority to provide care for civilians in the private sector.

3-61. Treatment of former military personnel

- a. Treatment is authorized for former military personnel suspected of Service connected diseases or injuries who have been separated with a permanent disability rating.
- b. Former military personnel involuntarily separated may be authorized temporary extended health benefits through the Continued Health Care Benefit Program.
- c. Former military personnel may be admitted to an Army MTF for diagnosis and treatment when the DOD has established a program(s) and a protocol to evaluate Service-connected impairments (for example, malaria, Agent Orange). Former military personnel determined ineligible for these services will be referred to the nearest VA treatment

facility. When authorized by the DA, DOD, or Congress, former military personnel and their family members may be extended benefits due to involuntary separation.

3-62. Returned military prisoners of war and their family members

Returned military prisoners of war and their family members (as defined in the glossary) are eligible to receive health care in MTFs for a period of up to 5 years commencing on the date the member is separated from the Service for reasons other than retirement. These former members and their family members will be furnished care on the same priority as retired members and their family members.

a. Outpatient care will be furnished without charge. Charges for hospitalization will be at the same rates as those prescribed for retired members and their family members.

b. Movement to, from, and between MTFs will be provided only through local military transportation and military aeromedical evacuation service.

c. These individuals will be furnished care as designees of the Service where treatment is obtained and will be identified by authorization issued by the Office of the appropriate Service Secretary on an individual family basis. They will not be issued military ID cards.

d. These former members and their family members are eligible for care only in Army, Navy, and Air Force MTFs.

3-63. Donors and recipients of organ transplants performed in MTFs

a. Normally, only those persons who have statutory entitlement to care in DOD MTFs or are covered by VA/DOD health care resource sharing agreements (38 USC 8111) and require this service are eligible for care in the Army Organ Transplant Program.

b. Living donors who are not DOD beneficiaries may be used as donors for DOD recipients subject to approval of the Secretary of the Army and receipt of designee status. (See para 3-50.)

c. Living organ donation by an AD soldier to a non-DOD beneficiary is permissible but requires approval from the Office of The Surgeon General (OTSG), ATTN: DASG-HS-AP, 5109 Leesburg Pike, Falls Church, VA 22041-3258. Circumstances requiring more immediate response may be approved telephonically by the OTSG (AR 40-3).

d. Former beneficiaries with failed transplants and beneficiaries who lose entitlement while awaiting a cadaver have no status under the Army Organ Transplant Program. Exceptions may be considered on a case-by-case basis under the Secretary of the Army Designee Program. However, consideration should be given to assisting these categories in establishing coverage under Medicare or other nonmilitary programs. Requests for Secretary of the Army designee status will be processed as prescribed in paragraph 3-50 and will be supported by clinical justification.

e. Foreign nationals are not eligible for transplant services.

f. The Army assumes no liability in the case of a non AD donor whose donation results in mortality. Exception to this position will apply only under circumstances giving rise to a claim or action under the Federal Tort Claims Act.

3-64. Civilian faculty members of the Uniformed Services University of Health Sciences

Civilian faculty members of the Uniformed Services University of Health Sciences are authorized care in Army MTFs on a worldwide basis as Secretarial designees. Charges for care will be as stated in appendix B and will be collected locally from the individual.

3-65. Civilians in a national or foreign disaster

Civilians requiring medical treatment as a result of national or foreign disasters are authorized care in Army MTFs under the policies outlined in AR 500-60. Reimbursement for care provided these individuals will be obtained from the agency in charge of the disaster relief activities.

3-66. Unremarried former spouse

Certain unremarried former spouses of soldiers are authorized health benefits, depending on the length of the marriage (must be at least 20 years) and amount of time the marriage overlapped the soldier's creditable service.

a. *Twenty-twenty-twenty former spouse.* The unremarried former spouse of a member, married to the member or former member for a period of at least 20 years, during which period the member or former member performed at least 20 years of service that is creditable in determining the member's or former member's eligibility for retired or retainer pay, or equivalent pay, is entitled to care according to this chapter. (Former spouses of RC members, who have not yet attained age 60 and qualified for retired pay, are not entitled to care until the date the former member attains, or would have attained, age 60.)

b. *Twenty-twenty-five former spouse.* The unremarried former spouse described in a above, except that the period of overlap of marriage and the member's creditable service was at least 15 years, but less than 20 years, is entitled to care as in paragraph 3-11 if—

(1) Final decree of divorce, dissolution, or annulment of the marriage was before April 1, 1985; or

(2) Marriage ended on, or after, September 29, 1988, entitling the former spouse to health benefits for 1 year, beginning on the date of the divorce, dissolution, or annulment.

District Office 1-Boston
U.S. Department of Labor, OWCP
One Congress Street, Eleventh
Floor
Boston, MA 02114

District Office 2-New York
U.S. Department of Labor, OWCP
201 Varick Street, Room 750
New York, NY 10014

District Office 3-Philadelphia
U.S. Department of Labor, OWCP
Gateway Building, Room 15200
3535 Market Street
Philadelphia, PA 19104

District Office 6-Jacksonville
U.S. Department of Labor, OWCP
214 North Hogan Street, Suite
1006
Jacksonville, FL 32202

District Office 9-Cleveland
U.S. Department of Labor, OWCP
1240 East Ninth Street, Room 851
Cleveland, OH 44199

District Office 10-Chicago
U.S. Department of Labor, OWCP
230 South Dearborn Street,
Eighth Floor
Chicago, IL 60604

District Office 11-Kansas City
U.S. Department of Labor, OWCP
City Center Square
1100 Main Street, Suite 750
Kansas City, MO 64105

District Office 12-Denver
U.S. Department of Labor, OWCP
1801 California Street, Suite
915
Denver, CO 80202

District Office 13-San Francisco
U.S. Department of Labor, OWCP
71 Stevenson Street, Second
Floor
San Francisco, CA 94105

District Office 14-Seattle
U.S. Department of Labor, OWCP
1111 Third Avenue, Suite 615
Seattle, WA 98101

District Office 16-Dallas
U.S. Department of Labor, OWCP
525 Griffin Street, Room 100
Dallas, TX 75202

District Office 26-Washington,
DC
U.S. Department of Labor, OWCP
800 N. Capital Street, N.W.,
Room 800
Washington, DC. 20211

Figure 3-1. OWCP address list

OFFICE SYMBOL (MARKS Number)

MEMORANDUM THRU (MTF PAD)

FOR (USAMEDCOMM ATTN: MCHO-CL-P, 2050 Worth Road, Fort Sam Houston,
TX 78234-6010)

SUBJECT: Requests for Designees of the Secretary of the Army

1. References:

- a. AR 40-400;
- b. (MACOM or agency supplement to AR 40-400.)

2. Background. (Provide background information identifying the problem, condition, or reasons leading to the request.)

3. Objective. (Briefly summarize the overall purpose, goal, or benefit to be achieved in accepting this request.)

4. Basis for request. (As a minimum, the following information will be included in the request, if applicable.)

- a. Diagnosis of the condition for which care is requested and the name, office address, and telephone number of the physician who most recently treated the condition.

- b. Name, address, and age of the prospective designee and his or her relationship to a member of the Uniformed Services.

- c. Documentation from the MTF is attached verifying that the requested care is available for the prospective designee.

- d. Name, rank, SSN, Service affiliation, address, and telephone number of the military sponsor and whether separating from the Service was on a voluntary or involuntary basis.

- e. For patients who are or have been eligible for care in Army MTFs, verification through the DEERS of the expiration date for eligibility for care.

- f. Length of time for which designee status is requested.

- g. Whether or not access to the aeromedical evacuation system is necessary.

- h. Attempts made to obtain care from State and local agencies.

- i. Documentation attached that the applicant has been advised of care available under the Continued Health Care Benefits Program.

- j. Any other information or documentation that the requester believes will strengthen justification for approving the request.

SIGNATURE BLOCK

Figure 3-2. Sample format memorandum for Secretary of the Army designees

Chapter 4

Management and Accountability of Hospitalized Patients

4-1. Patient control

a. Military patients. The MTF commander has administrative authority to restrict liberty of a patient under his or her command, provided such restriction, restraint, or seclusion is not imposed as punishment for an offense or for disciplinary reasons, but is necessary for proper medical care and treatment of a patient (AR 600-20 and the Joint Commission on Accreditation of Healthcare Organizations Accreditation Manual for Hospitals). Ward absences may be granted by clinical personnel for short absences not past 2400 hours. Applicable charges and an occupied bed day will accrue during the absence. Absences past 2400 hours may be in a subsisting out status and can be granted according to paragraph 5-7.

b. Nonmilitary patients.

(1) Nonmilitary patients admitted to an MTF have a responsibility to conform to the rules and regulations governing the operation of the facility. If a patient, who has no statutory right to medical care, fails or refuses to comply with the facility rules and regulations, he or she may be discharged from the facility at the direction of the MTF commander. Whenever a beneficiary of the VA is discharged from a facility under these conditions, the patient administrator will notify the regional VA office.

(2) Nonmilitary patients who are well enough to be absent from the facility will be discharged instead of being put on pass. Passes will not be granted to nonmilitary patients.

4-2. Patient identification

a. Newborn. Immediately after birth and prior to removing the infant or mother from the delivery room, two identical ID bands will be placed on either the wrists or the ankles of the infant. A third identical band will be placed on the wrist of the mother. ID data will include the mother's full name, mother's register number, sex of the infant, and date of birth. Local procedures will be established that identify staff authorized to remove infants from the nursery and other (locally designated) patient care settings. Procedures will be locally developed and periodically tested that ensure protection and security of infants against abduction. A positive comparison of infant and mother ID data will be made by the individuals removing an infant from an area within the MTF. Prior to discharge of the infant, one infant ID band will be included with his or her clinical record. Parents will be advised to register the infant in DEERS at the earliest opportunity.

b. Pediatric and adult patients. A tamper proof, nontransferable ID band will be placed on either wrist of the patient. This band will be checked before each procedure performed on the patient. The band will include the patient's full name and admission register number. When medical conditions contraindicate, the ID procedure may be altered.

4-3. Comfort items for patients

a. General. The hospital commander may designate an officer under his or her command to account for a sum of money not to exceed \$50 per month from the accrued pay of a member in bed-occupied status who has been declared mentally incompetent according to the provisions of a sanity board. (See para 7-6.) This money may be used only for the purchase of comfort items for the benefit of the patient. Withdrawals may be authorized only when all the following exist:

- (1) A legal guardian or other legal representative has not been duly appointed to act for the member.
- (2) The soldier has no other funds available for use in his or her behalf. (Monies held in trust in the patients' trust fund (PTF) to his or her credit will not be considered as funds available.)
- (3) The patient requires the items to be purchased, as determined by competent authority.
- (4) The patient's condition is such that he or she is able to use the items purchased.
- (5) Such items are beneficial to the patient's comfort and well-being.

b. Receipt. The funds will be hand receipted by the officer designated on behalf of the mentally incompetent. The voucher will reflect this paragraph and regulation as the authority for receipt.

4-4. Government property

Military patients sent to an MTF will leave individual weapons and organizational equipment with their unit. If a patient brings Government property to an MTF, it will be properly safeguarded. When a patient is admitted, his or her personal effects will be inventoried immediately and Government-owned weapons and other organizational equipment will be returned to the patient's assigned unit, if possible, and a receipt obtained (DA Form 4160 (Patient's Personal Effects and Clothing Record)) and filed (File Number (FN) 40-400aa) (AR 25-400-2). Otherwise, the commanding officer of the medical holding unit (MHU) or medical company will place any other Government equipment in the custody of their supply personnel. Weapons that cannot be immediately returned to the parent unit will be receipted to

the local military police authority. DA Form 4160 is available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web (WWW.usapa.army.mil).

4-5. Personal effects

Patient clothing and baggage will be secured based upon patient needs. The MTF commander determines when the needs of the organization require establishment of a baggage room. Night stands and lockers on wards may be used to accommodate patient clothing. Patients should be encouraged to deposit valuables into the PTF. (See chap 11.) The MTF commander may exempt or require any patient to secure clothing, baggage, and any other personal effects while they are a patient at the facility. When clothing and effects are accepted in the baggage room, an original and two copies of DA Form 4160 will be prepared. The patient's personal property, other than money or valuables, will be inventoried and listed on all copies of DA Form 4160, with one copy placed in a clothing bag. The bag will be tagged for identification using DD Form 599 (Patient's Effect Storage Tag) and secured. The contents of luggage or other containers in the patient's possession will be tagged (DD Form 599) and listed on DA Form 4160. Each piece of luggage or container not equipped with a secure locking device should be sealed in the patient's presence. All items inventoried will be listed in the first numbered column of DA Form 4160. All entries on the form will be made in ink. The column will be dated and then initialed by the patient and the clerk. DD Form 599 may be obtained through normal distribution channels. One copy will be given to the patient as his or her receipt and the original copy retained in FN 40-400aa (AR 25-400-2).

a. Patients unable to sign. An officer or administrative officer of the day will witness the inventory and sign DA Form 4160 for the patient when the patient cannot/is not a witness to the inventory.

b. Withdrawals. When a patient withdraws any of his or her clothing or property, the inventory column of DA Form 4160 (both copies) will be redlined and any remaining balance entered in the next numbered column. When a patient withdraws all of his or her clothing and property, he will surrender his or her copy of DA Form 4160. If a patient leaves on a temporary basis and withdraws all of his or her clothing and effects, the form may be held until his or her return and then, beginning with the next open numbered column, be reused.

c. Discharge. Upon discharge, the patient and the clerk will sign the spaces on the reverse of the original copy of DA Form 4160 which is then dated and filed. (The patient's copy will be destroyed.) If a patient dies, absents him or herself without leave, deserts, or otherwise unaccountably departs from the hospital, his or her effects will be provided to the Summary Court Martial Officer as prescribed by AR 638-2.

d. Transfer. When transferred to another MTF, personal effects may accompany the patient or may be forwarded (AR 700-84 and AR 735-5). Excess clothing and baggage of patients transferred to a community nursing home will be shipped by the patient's unit commander to the patient's home or other location designated by the patient prior to transfer. Clothing and baggage of mentally incompetent patients, which cannot be released to a person eligible to receive effects, will be transferred to the VA and managed according to VA instructions.

e. Loss of DA Form 4160. If a patient loses his or her copy of DA Form 4160, a duplicate will be prepared, prominently marked "COPY," and given to the patient. A notation will be made on the clothing room original of the date the duplicate was issued.

f. Loss of personal effects. If personal clothing, personal effects (other than PTF items), or Government-issued clothing or equipment become lost through no fault of the patient, the patient will be compensated. When such a loss occurs, the patient administrator will prepare a memorandum which will serve to—

- (1) Relieve the soldier of liability for Government-issued clothing or equipment.
- (2) Serve as evidence to claim reimbursement from the servicing claims office for lost personal clothing, effects, or personally purchased Government-issued items.

4-6. Patient accountability and admission processes

a. Approved automated systems (for example, Composite Health Care System (CHCS) or Theater Army Medical Management Information System (TAMMIS)) technical manual (TM) procedures, forms, and reports are used in support of admission processes when available. (See automation system manual specific to the system.) DA Form 3648 (Coding Transcript-Individual Patient Data System) will be used during the admission process when automated systems are not available. Automated systems are designed to support the patient accountability processes of this chapter. Manual admission processing is performed as specified in the Medical Services Account Users' Manual.

b. The AAD office performs admission processing when a privileged provider desires to admit, discharge, or carded for record only (CRO). Patients requiring immediate emergency care are admitted directly to the treatment setting or service and admission processing is performed secondary to treatment. Deaths in the emergency room and deaths classified as dead on arrival (DOA) are not recorded as admissions. Procedures are locally developed for the admission of prisoners, patients with contagious diseases (for example, tuberculosis), psychiatric conditions, and victims of disasters.

c. Admitting officers use DA Form 2985 (Admission and Coding Information) to authorize an admission. The admitting officer will enter on either of these forms the patient's name, ward, time, date of admission, admission diagnosis, and signature. All remaining entries are completed by AAD personnel. DA Form 4029 (Patient Clearance

Record) is used as a means of ensuring that a patient clears all necessary hospital activities before discharge (for example, PTF, AAD). DA Form 2985 and DA Form 4029 are available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web (WWW.usapa.army.mil).

d. Admission processes include but are not limited to—

- (1) Verifying eligibility for care.
- (2) Collecting other information required for preparing medical records and reports.
- (3) Initiating the inpatient treatment record (ITR).
- (4) Furnishing information to patients concerning advanced directives, living wills, and organ donations.
- (5) Obtaining insurance information.
- (6) Identifying patients on admission (ID bands). (See para 4-2.)
- (7) Inventorying personal effects and clothing. (See para 4-5.)
- (8) Receiving PTFs.
- (9) Coordinating air evacuations and transfers of patients.
- (10) Providing standard and ad hoc reports for information management and accountability of patients which may include but are not limited to the following: admissions by diagnosis; admission, discharge, and transfer notifications to units; alpha rosters of patients; patient diagnosis and procedures; projected admissions; inpatient histories; remaining over night rosters; ward rosters; absent sick patient rosters; casualty and command interest rosters; long-term patient rosters; MHU rosters; status out rosters; admission injury rosters; air evacuation bed capability status; and recapitulation table of inpatients.
- (11) Advising patient of financial responsibility for care to be received.

4-7. NATO STANAG 2132 and ABCA QSTAG 470 International Agreement requirements

NATO countries are defined in paragraph 3-18a. ABCA countries include Australia, Canada, New Zealand, United Kingdom, and the U.S. The following requirements apply when military personnel of NATO or ABCA countries are patients in an Army hospital.

a. Any medical unit that admits, treats, transfers, and discharges nationals of the other NATO/ABCA countries has the responsibility to notify—either direct or through the reporting nation's staff channels—the national authority about casualties of that nation.

b. Patients considered by the appropriate medical authority to be “Very Seriously Ill” (VSI) and/or “Seriously Ill” (SI) will be reported in special lists. Every variation of these special lists, as well as deaths in medical installations, will be reported immediately to allied authorities and to the casualty area command (CAC) responsible in the area in which the casualty was hospitalized. (Also see para 6-2e.) The loss of a hand, foot, limb, or eye will also be included.

c. The minimum information to be reported to parent nations is as follows:

- (1) Designation and nationality of medical unit issuing list.
- (2) Serial number and date of issue of list.
- (3) Personal ID number.
- (4) Rank/grade.
- (5) Surname and initials of forenames.
- (6) Unit/regiment.
- (7) Nationality of the casualty's unit/regiment.
- (8) Diagnosis. (Also showing whether VSI or SI and indicating if loss of a hand, foot, limb, or eye has occurred).
- (9) Category—
 - (a)* Hostile casualty.
 - (b)* Non-hostile accident/injury.
 - (c)* Sick/disease.
- (10) Date of admission, transfer out, or discharge.
- (11) Unit to which transferred or discharged (show nationality of unit).
- (12) If died, to be shown as “Died” giving date.

d. When a member of NATO/ABCA forces dies and is examined by a medical officer, the medical officer should determine the cause of death and forward a completed death certificate to the deceased's parent nation.

Chapter 5 Dispositioning Patients

5-1. General policies

a. Before military outpatients or inpatients are returned to their units, they will be evaluated for duty restrictions. Each member will also be evaluated under such special standards as may be applicable (for example, aviation, diving,

airborne, or special forces). The long-range effect, if any, on the health and well-being of the patient after return to regularly assigned duties will be considered in the disposition to a duty status. A person who is unable to meet special standards but is otherwise fit for duty will not be continued in a disabled status.

b. Military patients will be available for treatment at all times. Leave will not be granted when it will delay a patient's disposition, except for emergencies.

c. Army military patients who are administratively unsuitable for retention will be processed as prescribed in AR 600-8-24 and AR 635-200.

d. Patients discharged from an MTF on weekends or holidays should be administratively processed on the preceding workday.

e. Convalescent leave may be granted according to AR 600-8-10. All administrative actions should be expedited. However, no patient will be retained in an MTF solely to complete administrative actions. Military patients will not be kept in an MTF longer than is necessary to receive optimum hospital benefit.

f. When efforts to disposition a patient are not successful, the case will be brought to the attention of the proper major Army medical command. When a patient has been attached or assigned to an MHU for 12 months, a report will be provided by the attending physician to the Deputy Commander for Clinical Services (DCCS) describing the patient's treatment and disposition plan.

5-2. Responsibility for dispositions

a. *Army MTF commanders.* MTF commanders will disposition patients under their jurisdiction and will evaluate medical fitness of military patients.

b. *Attending medical officers.* Medical officers are responsible to the MTF commander for the timely care of assigned patients and their continual evaluation for early dispositions.

c. *MEB.* The MEB assists the MTF commander in determining the medical fitness, mental competence, and disposition of patients. (See chap 6.)

d. *The Secretary of the Army.* The responsibilities of the Secretary of the Army in administering the Physical Disability Program are exercised through the U.S. Army Physical Disability Agency. Procedures are addressed in AR 635-40.

5-3. Types of disposition for Army members

a. *Full duty.* Patients who are medically fit to perform duty without restrictions or assignment limitation will be returned to full duty. This disposition may be made by the attending medical officer or upon the approved recommendation of an MEB.

b. *Temporarily restricted duty (temporary profile).* This disposition will apply to patients who are recovering from sickness or injury and are likely to become fit to perform duty. Such patients will be evaluated at least once every 3 months with the goal of upgrading their duty status. No person may remain in this status for more than 12 months. Such disposition involving 3 months or less should be made by the attending medical officer (AR 40-501).

c. *Trial duty (temporary profile).* Patients whose fitness for duty is questionable may be recommended for trial duty. A person on such duty will be evaluated at least once every 3 months with the goal of upgrading duty status or separate from the Service, if appropriate. Persons will not be retained on trial duty for more than 12 months.

d. *Duty with permanent assignment limitations (permanent profile).* Patients who meet retention standards and who can perform duty with specific permanent assignment limitations will be permanently profiled. Those who do not meet retention standards and who are recommended for continuance on AD as outlined in AR 635-40 will have their permanent assignment limitations identified by the MEB processing the case.

e. *Duty for separation or separation recommended.*

(1) Patients who do not have a condition listed in AR 40-501 and who are scheduled for any administrative separation or retirement, will be returned to duty for separation. This disposition may be made by either the attending medical officer or the MTF commander.

(2) Patients who have a condition listed in AR 40-501 and do not require active hospitalization, will be processed according to AR 635-40. This applies when the person is eligible for and elects separation for an EPTS condition which has not been aggravated by service. This disposition can be made by the MEB on an outpatient basis.

(3) An enlisted patient who does not have a condition listed in AR 40-501 and did not meet the procurement medical fitness standards (AR 40-501) at the time of induction or initial enlistment will be processed for separation according to AR 635-200. To be processed under AR 635-200, the condition must have been identified within the first 6 months and an EPTS board initiated.

(4) Patients who do not have a condition listed in AR 40-501 but are considered unsuitable for further military service by either MEB authority or unit commander, will be returned to duty with separation recommended under the appropriate administrative regulation.

f. *Transfer to a VA treatment facility or other MTF.* (See para 5-18a.)

g. *Referral to a PEB.* (See para 7-21.)

h. Absent without leave (AWOL). When patients are AWOL for 10 consecutive days, their clinical records will be closed. This disposition is made by the attending medical officer.

i. Death.

5-4. Recommendation for change of duty or station

An MEB will process U.S. military patients with physical defects or medical conditions that warrant a change of duty or station. The medical responsibility is either to evacuate the patients or to advise their unit commander of the medical reasons for the change. Under no circumstances will the patient be given a written statement and instructed to apply for a transfer or change of assignment because of medical reasons.

5-5. Return of Army military patients from overseas to CONUS for medical reasons

Overseas MTF commanders may return Army military patients from overseas to CONUS for medical reasons when, after coordination with the member's commander, they determine that such action is in the best interests of the Army and the patient.

a. MTF commanders will determine whether a patient being returned to CONUS under this paragraph will appear before an MEB before evacuation.

b. If hospitalization or active medical supervision is required while in a travel status, the patient will be evacuated through medical channels.

c. If hospitalization or active medical supervision is not required while in a travel status, the patient will be returned to CONUS through regular administrative channels by the fastest means. Normally, Government transportation will be used.

d. When it is determined that a patient is to be returned to CONUS in an inpatient status, a request for MTF designation will be sent through normal medical regulating channels to the Global Patient Movement Requirements Center (GPMRC), Scott AFB, IL 66225-5300, according to AR 40-350/AFR168-11/BUMEDINST 6320.1E/PHS CCPM 60/COMDTINST M6320.8B/NOAAR 56-52C. Also, for those patients who will be returned to CONUS administratively, information required by AR 40-350/AFR168-11/BUMEDINST 6320.1E/PHS CCPM 60/COMDTINST M6320.8B/NOAAR 56-52C will be included in the request.

e. Inpatients will be transferred as soon as possible after receipt of an MTF designation from GPMRC. The patient will be assigned or attached to the MHU of the designated MTF as provided in paragraph 8-1.

f. The MTF commander who starts action to return a patient to CONUS administratively will determine whether leave or delay en route is medically sound. If not, such patients will not be granted leave or delay en route.

g. MTF commanders will assure that the ITR, when applicable, and the health record (HREC) are assembled before the patient's departure. They will also advise the personnel records custodian regarding the designated CONUS MTF where the patient will be assigned or attached. Records will be assembled and sent as specified below.

(1) If the patient is being returned through medical channels and attached to the receiving CONUS MTF, only a copy of the ITR will accompany him or her.

(2) If the patient is being returned through administrative channels and attached to the CONUS MTF, the patient will hand carry his or her HREC and ITR when no leave or delay en route is authorized. When leave or delay en route is authorized, the patient will hand carry the HREC; however, the ITR will be airtailed to the receiving MTF immediately upon completion of the record. The patient's military personnel records jacket (MPRJ) will be retained in the overseas command.

(3) If the patient is being returned through administrative channels and assigned to the CONUS MTF, he or she will hand carry the MPRJ with HREC and ITR when no leave or delay en route is authorized. When leave or delay en route is authorized, the patient will hand carry the MPRJ with HREC; however, the ITR will be airtailed to the receiving MTF to arrive before or upon arrival of the patient.

(4) When hand carrying personnel records is not advisable (AR 600-8-104), these records will be sent by mail to the receiving MTF to arrive before or upon the arrival of the patient.

h. The following members in an overseas command will be processed for disposition in the overseas command:

(1) Hospitalized members who are authorized separation in an overseas command (AR 600-8-24 and AR 635-200). TDRL members who are residing in an overseas area while being evaluated will be processed in that command if the MTF has the capability.

(2) Members being considered for referral to a PEB who do not require evacuation to CONUS for medical treatment. MEB proceedings will be prepared according to this regulation and AR 635-40 and forwarded to the appropriate PEB. If such members demand a formal hearing, they will be ordered to a PEB in CONUS on TDY status. (AR 635-40 contains detailed procedures.)

i. PCS evacuation orders on officer patients should receive distribution as shown in AR 600-8-105.

5-6. Length of hospitalization for AD Army soldiers

a. Army personnel on AD for more than 30 days who are likely to be medically fit for return to duty within 12 months are given maximum hospital benefits.

b. Patients not likely to be medically fit for return to duty within 12 months will be processed for disposition after receiving optimum hospital benefit. An MEB/PEB is appropriate because these patients may continue treatment in a TDRL/permanent disability retired list status.

c. Active Army personnel who will require hospitalization or disability processing beyond their term of service may be extended on AD upon approval by U.S. Total Army Personnel Command (PERSCOM) for officers or by general courts-martial authority for enlisted personnel. AR 600-8-24 defines procedures for extension of officers and AR 635-200 for extension of enlisted personnel. Officer extensions will be processed through OTSG (DASG-PTZ), 5109 Leesburg Pike, Falls Church, VA 22041-3258. MEB/PEB processing for soldiers extended on AD will be closely monitored and expedited to the extent possible.

d. For RC soldiers who require hospitalization or disability processing beyond their duty period, refer to AR 135-381.

5-7. Use of subsisting out status

Military patients may be permitted to live outside the MTF in a subsisting out status while receiving required medical care. (This status is used to distinguish these days from occupied bed days.) Subsisting out status applies to inpatients whose constant presence in the hospital is not essential to treatment. Arrangements for subsistence and lodging must be acceptable to the MTF commander. Patients discharged but retained as attached to the MHU may be placed in a subsisting out status. Lodging used by subsisting out patients will be located within the vicinity of the MTF. The MTF commander will determine maximum distance for subsisting elsewhere. This status will not be used when another means, such as leave, is more appropriate or when the patient's needs can be met as an outpatient. Subsisting out status will not delay the final disposition of a patient from the MTF. Military patients in subsisting out status continue to be carried on the rolls (assigned or attached/inpatient or outpatient) of the MTF MHU. Patients subsisting out may be expected to report daily to the MHU and perform limited duty within the limits of profile restrictions. When patients subsist elsewhere, they do not accrue hospital charges.

5-8. Members on the temporary disability retired list

A person placed on the TDRL is legally required to undergo a medical examination at least once every 18 months. The purpose of the TDRL periodic medical examination is to—

- a. Determine the member's condition.
- b. Decide if a change has occurred in the disability for which the member was placed on the TDRL.
- c. Decide if the disability has become stable enough to permit removal from the TDRL.
- d. Identify any new disabilities incurred while the member has been on the TDRL. AR 635-40 contains guidance on the physical evaluation, reporting requirements, and disposition of TDRL patients.

5-9. Members of the RC and ROTC members

RC members on ADT orders that specify a period of 30 days or less or are on IDT, or full-time NG duty-to include ROTC members attending field training-will be evaluated for an MEB upon completion of hospitalization before release from the MTF.

a. Procedure following approved MEB action.

(1) RC patients who have a condition listed in AR 40-501 as the result of injury incurred or aggravated during a period of AD or IDT will be referred to an MEB.

(2) RC patients who are medically fit for limited duty or training will be released from the MTF.

(3) AR 145-1 contains special procedures affecting ROTC members. Disposition normally will be released from the MTF except as provided in (4) below.

(4) When a patient has attained maximum hospital benefit in an Army MTF and does not qualify for physical disability processing by the physical disability system, he or she will be released from the MTF or transferred to a nonmilitary medical facility. The MTF commander will arrange for the transfer of U.S. Army Reserve (USAR) and ROTC personnel. For NG personnel, the proper State Adjutant General will be contacted for assistance. When satisfactory arrangements cannot be made after reasonable effort, the case will be reported to the Commander, ARPERCEN, ATTN: ARPC-ZSG, 9700 Page Avenue, St. Louis, MO 63132-5200; the U.S. Army area commander; or the Army National Guard Readiness Center, ATTN: NGB-ARP-PC, 111 South George Mason Drive, Arlington, VA 22204, as appropriate, for disposition instructions. Reports will include a summary of all actions taken, two copies of the MEB proceedings (if appropriate), and a summary of all Federal service claimed by the member, if any, including the dates of such service. The patient's home of record, LD status, recommendations of the MTF commander, and copies of any pertinent correspondence will also be included. The Commander, USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Fort Sam Houston, TX 78234-6010 or the major overseas MEDCOM commander will be furnished a copy of the report.

b. Notification of disposition and separation.

(1) When a USAR member or an ROTC member is released from the MTF, the Commander, ARPERCEN, ATTN:

ARPC-ZSG, 9700 Page Avenue, St. Louis, MO 63132-5200 or the U.S. Army area commander, as appropriate, will be notified of the date and type of disposition.

(2) When a member of the NG is released from the MTF, the Adjutant General of the State concerned will be furnished the information in (1) above.

(3) RC members will be separated from their status by action of the MTF commander, when appropriate. ROTC members will not be separated from their status by the MTF commander without approval of higher authority as provided in AR 145-1 and AR 145-2.

5-10. U.S. Navy/Marines and U.S. Air Force military patients

a. When administrative units of the U.S. Navy or U.S. Air Force are stationed at Army MTFs, the parent Service unit is responsible for the disposition of these patients.

b. When no administrative detachments of the other Services are stationed at an Army MTF, disposition of these patients will be as follows.

(1) When fit for duty, the patient will be returned to his or her assigned organization and station. If the patient's organization or station is not known, assignment instructions will be requested from the parent Service. In addition, for Naval personnel, assignment instructions will be requested if the patient has been hospitalized more than 30 days.

(2) Requests will be addressed to—

(a) The commandant of the Naval district in which the MTF is located, for Navy and Marine Corps personnel.

(b) Chief of Staff, U.S. Air Force, Washington DC 20330-5000, for Air Force personnel.

(3) If not fit for duty, the patient will be reported through normal medical regulating channels for transfer to an MTF having final disposition authority.

c. MTF commanders will coordinate with local senior Service representatives who will prescribe disposition procedures for Navy and Air Force patients hospitalized in overseas MTFs unless otherwise directed by major overseas commanders.

d. Special problems not provided for above will be reported through command channels to USAMEDCOM, ATTN: MCHO-CL-P, Fort Sam Houston, TX 78234-6010.

5-11. Domiciliary care

a. Domiciliary care will not be provided in Army MTFs except when required for AD soldiers of the Uniformed Services who are awaiting completion of disposition procedures.

b. For other than AD patients, the actions in (1) or (2) below will be taken, if required, to expedite their transfer.

(1) Attempt to arrange transfer to a VA or other Federal treatment facility.

(2) Coordinate with social work service to assist the NOK in making arrangements for the patient to include contacting State and local agencies.

c. If none of the actions in b above can be taken, legal action may be considered. Legal action may vary depending on the law of the State where the action is taken. Generally, once a hospital undertakes treatment of a patient, it must act reasonably in removing the patient. Treatment must be continued if removal would or could aggravate the patient's condition or increase the risk of personal danger. The servicing SJA or legal advisor should be consulted if legal action is contemplated.

5-12. Sick call

The daily assembly of sick and injured AD soldiers for examination is established to provide routine medical treatment. Such patients require DD Form 689 (Individual Sick Slip). After examination, patients determined to be medically unsuitable for duty will be admitted as an inpatient or placed in an observation bed status at the MTF.

5-13. Prisoner patients

a. One or more of the following recommendations will be made for disposition of military prisoner patients whose sentences include punitive discharge or dismissal:

(1) Return to confinement to serve the remainder of the sentence. This recommendation is proper when the condition for which a prisoner was hospitalized is in a satisfactory state of remission or control. This applies whether or not the prisoner meets retention standards unless return to confinement will compromise his or her health or well-being or prejudice the interests of the Government. When appropriate, an MEB will recommend assignment limitations. A copy of the approved proceedings will be sent to the proper confinement officer. A cover letter may identify any aspects of confinement that will medically affect the prisoner.

(2) Transfer to an MTF that furnishes specialty care if further treatment may result in substantial improvement. Military prisoners requiring hospitalization at Army MTFs other than the local supporting hospital must be processed through GPMRC.

(3) Remission of sentence by the Secretary of the Army, or change in type of discharge, concurrent with transfer to a VA treatment facility or State institution, or release to care of NOK or to self-care. Transfer to a VA treatment

facility will be done only when the punitive discharge or dismissal from service did not result in a dishonorable discharge.

(4) Transfer to a VA treatment facility or State institution upon expiration of sentence. Transfer to a VA treatment facility will be done only when the punitive discharge or dismissal from service did not result in a dishonorable discharge.

(5) Transfer under the provisions of AR 190-47 to a Federal correctional facility having medical or psychiatric treatment facilities.

b. An MEBs recommended disposition for a prisoner may result in sentence remission, change in type discharge, or transfer to a Federal correctional facility. The original and duplicate of the MEB proceedings will be sent through Commander, USAMEDCOM, ATTN: MCPM, 2050 Worth Road, Fort Sam Houston, TX 78234-6000 for consideration and action required by AR 190-47.

c. A prisoner hospitalized beyond the expiration of his or her confinement will be carried by the Army MTF as an AD patient if punitive discharge or dismissal has not been finalized. If discharge or dismissal from the Army has been accomplished and the sentence to confinement has expired, the person will be carried by the Army MTF as a pay patient until disposition can be made.

d. The commander of the confinement facility is responsible for administrative control of the prisoner. When there is an early expiration of sentence, and upon request of the MTF commander, the confinement facility commander may administratively forfeit good conduct time according to AR 633-30/AFR 125-30. This may be done to permit final action in the case before the prisoner's sentence to confinement expires.

e. A prisoner who is eligible to meet a PEB according to AR 635-40 will not receive a disposition other than to an Army MTF.

f. If a prisoner is not eligible for return to duty solely because of a mental disorder that arose after confinement, the Secretary of the Army may substitute an administrative discharge for a discharge or dismissal executed according to the sentence of a courts-martial. Similar action also may be taken when it appears after trial that, at the time of the offense, the prisoner was not mentally responsible for his or her acts under accepted legal standards. Recommendations for such action will be forwarded as outlined in *b* above.

g. Where the results of detailed psychiatric evaluation show that specialized neuropsychiatric treatment would not result in a substantial improvement or that further evaluation and observation are not warranted, the prisoner will be examined by an MEB. The board will be convened at the place of confinement to consider disposition.

h. Informational copies of correspondence regarding disposition of prisoner patients will be furnished the commander of the appropriate confinement facility.

5-14. Psychiatric patients

a. At MTFs that do not furnish specialized psychiatric care, the patient will be transferred to an MTF that furnishes the required care. This procedure will apply when most of the available clinical evidence indicates a military patient has a psychiatric condition and treatment, observation, or evaluation for a period of 7 days is indicated. The transfer will normally take place within 7 days of the date of admission.

b. At MTFs designated as psychiatric STSs, patients with psychosis ordinarily will undergo prolonged periods of observation to determine the permanency of the disability. The patient's response to treatment will be evaluated as soon as practicable after a definite diagnosis has been made. When treatment does not result in substantial improvement, disposition will be made as quickly as practicable. Usually intensive treatment for a period of under 90 days will be sufficient to establish the degree of disability and provide optimum improvement. (See para 5-15 for processing of psychiatric prisoner patients.)

c. A commander is responsible for exercising all reasonable measures to protect the personal affairs of a psychiatric patient as well as other members of the command. Legal assistance officers will be contacted for counsel and advice. Psychiatric soldiers, despite their mental illness, may be sufficiently competent to execute a legally acceptable power of attorney or other instrument authorizing another person to act on their behalf in personal matters. Mental incompetence may vary in degree and in relation to specific situations. Opinion as to competency will be obtained from a psychiatrist on specific situations that arise in the settlement of personal affairs.

5-15. Psychiatric prisoner patients

When a prisoner suffering from psychosis is admitted to an MTF or local confinement facility, the MTF commander will ascertain whether the issue of insanity was raised at the time of trial or if there is anything in the record of trial that may support a reasonable doubt as to the patient's sanity at the time of the offense or trial. If the information concerning the patient's sanity is not in the patient's available records, this information will be requested from HQDA (DAJA-CL), Washington, DC 20310-2200. When received, the information will be included with the patient's ITR. (See para 7-6 for sanity board policy.)

5-16. Notification of release of criminal Army members

a. A criminal Army member, as used in this paragraph, is a psychiatric patient who has a history of reported

involvement in major crimes or antisocial behavior and is considered to have significant potential for recurrence of such behavior. Examples are crimes of violence such as murder, rape, or prolonged absences associated with threats of violent behavior. When such patients have been administratively cleared for medical separation from the Service, they will be reported by the Army MTF to OTSG (DASG-HSZ), 5109 Leesburg Pike, Falls Church, VA 22041-3258. Copies of the following documents will be included in the notification, if available:

- (1) Applicable criminal investigation activities, military police, and/or civilian police investigations.
 - (2) Investigations under the provisions of The Uniform Code of Military Justice (UCMJ), Article 32.
 - (3) SJAs advice to the general courts-martial.
 - (4) Record of trial.
 - (5) Sanity board proceedings. (See para 7-6.)
 - (6) MEB proceedings including a copy of the narrative summary (see para 7-24) prepared in lieu of sanity board proceedings or prepared separately.
 - (7) Indictments, complaints, other investigative files, and court orders.
 - (8) Proposed date, place, and basis of release from the MTF including identification of the receiving facility and estimated date of separation from the Service.
- b.* Absence of any of the listed documents in a above must be explained.
 - c.* Reports required above will be dispatched no later than 72 hours before actual physical disposition (departure) of the patient from the MTF.
 - d.* If reporting as described in this paragraph is questionable, the case will be forwarded as prescribed in a above.
 - e.* Notifications prescribed by this paragraph are exempt from reports control under AR 335-15.

5-17. Final disposition procedures for military patients

a. Patients who are fit for duty will be returned to duty as soon as possible. Attached military patients will be returned to their units of assignment. Those assigned to MHUs will be reported for reassignment per paragraph 8-7 and 8-8. (See chap 7 for MEB requirements.)

b. Patients who are unfit for duty and are assigned to MHUs will be processed for separation by the transfer point which supports the MTF. Patients who are not assigned to the MHU will be returned to their units of assignment for separation action. The additional instructions in (1) through (5) below apply.

(1) Patients who are fit for retention but do not meet procurement medical fitness standards will be processed as provided in paragraph 5-3 and AR 635-200.

(2) Patients who have been referred to PEBs and are approved for continuance on AD as provided in AR 635-40 will be processed according to instructions from the U.S. Army Physical Disability Agency (TAPD-PDB).

(3) Patients who are being or have been processed through the physical disability system and who do not require active inpatient medical supervision will be processed as indicated in (a) through (c) below. Assigned duties will be restricted to the degree required by profile. The narrative summary (SF 502) of such patients processed on an outpatient basis should show in detail the level of duties that the patient is able to perform.

(*a*) Assigned patients will be placed on duty with a nearby unit or with the MTF MHU as set forth in paragraph 8-9.

(*b*) Patients being processed on an outpatient basis will remain on duty with the assigned organization.

(*c*) Patients will be processed as directed by HQDA.

(4) If eligible, those patients who are being or have been processed through the physical disability system and require continued active medical supervision will be transferred to a VA treatment facility as soon as possible to await final processing. (See para 5-18.)

(5) Patients who are being or have been processed through the physical disability system and who require continued active medical supervision, but are not eligible for transfer to a VA treatment facility will be processed as soon as possible. (See para 5-18c.) Separation will take place within 72 hours of receipt of instructions from the U.S. Army Physical Disability Agency (TAPD-PDB) and will not be delayed for completion of disposition arrangements.

c. Procedures for retention of patients whose period of AD will expire while needing medical or dental care are contained in AR 135-200, AR 600-8-24, and AR 635-200.

5-18. Military patients requiring continued hospitalization or nursing home care after separation

When it is determined that a patient will not be able to continue active service, the MTF commander will begin action as follows:

a. Transfer to a VA treatment facility. Except for those with a dishonorable discharge, a request will be sent to GPMRC, Scott AFB, IL 62225-5300, requesting a bed designation in a VA treatment facility (AR 40-350/AFR168-11/BUMEDINST 6320.1E/PHS CCPM 60/COMDTINST M6320.8B/NOAAR 56-52C). When it is anticipated that a patient's hospitalization will be completed before the effective date of retirement or separation, the patient will not be processed for transfer to a VA treatment facility.

(1) A member being transferred from an Army MTF to a VA treatment facility for further hospitalization or nursing home care following PEB action will be ordered on PCS to such MTF as provided in (3) below. AD patients

transferred on PCS to a VA treatment facility will be assigned to the MHU of the MEDDAC in whose geographic area of responsibility (GAR) the VA treatment facility is located. Appropriate notifications will be completed according to this regulation. A patient transferred on PCS to a VA treatment facility will not be charged leave during the period of such care. The patient will be entitled to transfer of family members and shipment of household goods under provisions of the JFTR. Direct communication between Army MTF commanders and officials of the VA treatment facility is authorized in accomplishing patient transfers to VA treatment facilities.

(2) All requests for bed designations will be made at the earliest date which will allow completion of processing prior to the bed availability date. This date is usually within 2 weeks from the request. On receipt of a VA bed designation, the MTF commander will promptly send a copy to the PEB which is processing the member's case. If any condition should arise that will prevent completion of the patient's processing or transfer within the dates specified, immediate action will be taken to cancel or extend the VA bed designation through GPMRC.

(3) Before transfer of a patient to a VA treatment facility—

(a) Counseling will be accomplished according to AR 635-40. For mentally incompetent patients, the individuals acting in their behalf will be counseled.

(b) Appropriate separation certificates will be prepared according to AR 635-5 and AR 635-10.

(c) DD Form 214 will be prepared for all personnel according to AR 635-5. If it is impracticable to secure the member's signature in item 34, the item will be left blank. No notation of any kind will be placed on the copy of DD Form 214 or any other separation document presented to the member to indicate that he or she is mentally or otherwise incompetent to sign.

(d) Before moving a patient to a VA treatment facility, coordination will be made with GPMRC for a bed designation.

(4) The patient will be transferred to the designated hospital or nursing home upon receipt of the notification from GPMRC of a bed assignment in a VA treatment facility.

(a) Except for mentally incompetent patients, the transfer to a VA treatment facility will be accomplished at the earliest practicable date after the announcement of PEB findings that the patient will be permanently retired, placed on the TDRL, or discharged. To ensure timely processing, counseling for these patients will be completed as prescribed in paragraph 7-22. MEB results will be referred to the PEB promptly after transfer of the patient. Mentally incompetent patients will be transferred after completion of MEB action. See (c) below for special provisions for transferring spinal cord injury (SCI) patients.

(b) The following patients being evacuated from overseas may be transferred directly from the overseas MTF to a VA treatment facility in CONUS: severe brain injury patients, as soon as the MEB is completed; alcohol or other drug-dependent patients who meet the criteria outlined in AR 600-85; or those whose normal expiration-term-of-service date will not permit sufficient time in the local program to determine rehabilitation success or failure and who will have between 15 and 30 days remaining until discharge after arrival at the VA treatment facility.

(c) SCI patients will be transferred to VA SCI centers before completion of MEBs. Each MTF commander will establish procedures for the early identification and transfer of SCI patients. The general goal will be to transfer within 3 or 4 days from overseas and in no instance to exceed 12 days past the injury. The GPMRC will provide assistance as required in accomplishing transfers on a 24-hour basis. When the attending physician determines that the patient's transfer category is "URGENT" or "PRIORITY," the MTF may coordinate directly with the GPMRC, Scott AFB, IL 62225. Early dialogue between the attending physician and a physician at the VA SCI center will be the determining factor as to the method and time of the patient's transportability. Every effort will be made to ensure that the patient is sent to the VA SCI center nearest his or her selected place of residence. SCI patients arriving from overseas will go directly to the VA treatment facility without passing through an intervening CONUS military hospital.

(5) Careful consideration will be given to the availability and economical use of all Government transportation. Air Mobility Command routine air evacuation will be used whenever feasible. Arrangements for the transportation of patients to the VA treatment facility will be made by the Army MTF commander. If a patient is moved by means other than air evacuation, an after-the-fact report will be furnished to GPMRC by electrical message within 48 hours. An informational copy of the message will be furnished to the MTF having administrative responsibility for an Army patient in the particular VA SCI center.

(6) When warranted, an attendant or attendants will accompany the patient during the transfer from the Army MTF. (Attendant, as used here, includes medical personnel assigned to aeromedical evacuation flights.) The attendant will carry the records and documents listed in (a) through (e) below to the receiving MTF. When no attendant is required, the patient will carry a properly completed and authenticated copy of VA Form 10-10M. Other pertinent records and documents listed below will be forwarded by certified mail before the patient's departure.

(a) DD Form 675 (Receipt for Records and Patients Property) in duplicate. DD Form 675 is available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web (<http://www.usapa.army.mil/>).

(b) VA Form 10-10M. Attach a copy of VA Form 10-10M to VA Form 10-10 and enter "see attached summary" on VA Form 10-10M instead of completing the medical certificate. Only NLD cases will be required to complete items 20 and 21 of VA Form 10-10M. VA forms may be obtained from the field station having jurisdiction.

(c) A copy of the current ITR, including a copy of MEB proceedings.

- (d) X ray films, if any.
 - (e) A duplicate of VA Form 21-526E (Veterans Application for Compensation or Pension) if completed.
- (7) When the patient is ready for transfer, advance notification will be made by the most expeditious means available to the Director, VA treatment facility. It will include the patient's name, grade, SSN, and any applicable information regarding the following:
- (a) Whether the patient is ambulatory.
 - (b) Mode of transportation.
 - (c) Scheduled time and place of arrival.
 - (d) If accompanied by an attendant, the name and grade of the attendant.
 - (e) GPMRC cite number.
- (8) A request will be included for prompt notification of the hour and date of the patient's arrival. If delayed, the attendant will advise the losing Army MTF and the director of the receiving VA treatment facility of the change in scheduled time of arrival and reasons for the change.
- (9) When final disposition instructions are received by the Army MTF, the receiving VA treatment facility will be notified of the type and date of disposition.

b. Transfer to a community nursing home under VA contract. When the GPMRCs reply to a request for a nursing home bed designation indicates that the patient will be transferred to a community nursing home under VA contract, the location of the VA treatment facility responsible for the patient will be included. Responsibility of the VA treatment facility includes liaison with GPMRC and the community nursing home and authorization and payment for nursing home care. It also includes follow-up visits to the community nursing home to evaluate care of the patient, and submission of reimbursement requests to Commander, USAMEDCOM, ATTN: MCRM-F, 2050 Worth Road, Fort Sam Houston, TX 78234-6000. (See para 4-5d for disposition of patient's clothing and valuables when transferred to a community nursing home.) The provisions of a above apply to patients transferred to a community nursing home under VA contract except as follows:

(1) The records listed in a(6) above, with a copy of VA Form 10-1204 (Referral for Community Nursing Home Care), will be forwarded to the responsible VA treatment facility. That form may be obtained from the field station having jurisdiction.

(2) VA Form 10-1204 and SF 502 will be prepared by the Army MTF and will accompany the patient to the community nursing home.

c. Patients not eligible for care in a VA treatment facility. For patients not eligible for care in VA treatment facilities, the commander will initiate action to ensure proper disposition before separation. Disposition of psychiatric patients will be made under provisions similar to those in paragraph 5-23c. When the NOK will not accept the patient or provide the required care, the MTF commander will contact the proper civil authorities in the patient's State of residence and secure permission to transfer the patient to their custody. If permission is not granted, the commander will repeat the procedure with the civil authorities of the State from which the patient entered the Service if that State is different from the State of residence. Patients who do not have psychiatric conditions and are capable of making personal decisions will be assisted in arranging their own hospitalization. When the patient is in such condition that this cannot be done, the NOK will be asked to make arrangements for and accept the patient.

5-19. Request for medical and/or dental records

a. *Requests for medical and/or dental records held by Army personnel and records centers.*

(1) Requests for records of all personnel on AD will be addressed to Commander, U.S. Army Enlisted Records and Evaluation Center, ATTN: PCRE-FS, Indianapolis, IN 46249-5301.

(2) Requests for records of USAR personnel not on AD will be addressed to Commander, ARPERCEN, ATTN: ARPC-ZSG, 9700 Page Avenue, St. Louis, MO 63132-5200. For Army NG personnel not on AD, the requests will be sent to the State adjutant general concerned.

(3) When circumstances require the use of an electronically transmitted message to expedite the processing of a PEB case, the request should be stated as follows: "PEB action pending for (NAME, GRADE, SSN). Lend medical/clinical records. Member claims prior service in (BRANCH OF SERVICE) during the period (INCLUSIVE DATES) under (SERVICE NUMBER or SSN)."

(4) The records custodian indicated above will withdraw and send all available requested records to the requesting MTF. All records so obtained will be sent with the MEB proceedings when forwarded to HQDA for review.

b. *Records held by MTFs of other Services.* A request for records will be sent directly to the MTF concerned. It will include the patient's name, SSN (with financial management plan), dates of hospitalization, and register numbers if known. MTFs receiving such requests will expedite forwarding of all available original medical records. If the records requested are no longer on hand, the request will be sent to the activity to which the records were sent and the requesting activity informed of the referral.

c. *Records held by the VA.*

(1) A request for medical records from the VA will be sent directly to the VARO or field station known to have

custody of the veteran's file (claims or insurance). Locations of VAROs are listed in a VA pamphlet titled "Federal Benefits for Veterans and Dependents."

(2) When only the VA treatment facility records are desired, the request may be sent directly to the VA treatment facility concerned, if known.

(3) Requests for records when the location of the VA custodian is not known will be sent to the Department of Veterans' Affairs Central Office, Records Management Division (033A4), Washington, DC 20420 or the VARO nearest the Army MTF.

(4) All requests for records or abstracts of records data will include the name and SSN of the member, all available VA file information (claims and insurance numbers), the reason for the request, and the address to which the records will be sent.

(5) The VA will usually furnish original VA clinical records and x ray film in response to specific requests. If the originals cannot be released, copies of the final summaries of clinical records, x ray, or facsimiles may be furnished instead.

(6) After they have served their purpose, VA medical records will be returned directly to the VA installation that sent them unless they are duplicates. When the patient's case is not considered by a PEB, the records will be disposed of by the MTF after HQDA has made final determination. Any original records received in HQDA with PEB proceedings will be returned to the MTF for disposition. Copies of facsimile reproduction will not be returned unless specifically requested.

d. Action taken by the MTF upon transfer of a patient. If the patient is transferred to another MTF before receipt of records, the MTF commander may request that the records be sent to the gaining MTF or await receipt of the records and immediately forward them to the patient's new location. In any case, the commander of the losing MTF will notify the commander of the gaining MTF of the actions taken and the results obtained with respect to the procurement of the records. Copies of negative responses will be sent to the gaining MTF for submission to the PEB.

5-20. Patients of NATO nations

a. Patients who are members of NATO military forces will be transferred per ratified agreement (NATO STANAG 2061). The transfer will take place at the earliest opportunity under any of the conditions cited in (1) through (3) below.

(1) When an MTF of the patient's own nation is within reasonable proximity of the holding nation's facility.

(2) When the patient is determined to require hospitalization in excess of 30 days.

(3) When there is any question as to the ability of the patient to perform duty upon release from the MTF.

b. All clinical documents, to include x rays, relating to the patient will accompany him or her on transfer to his or her own national organization. AR 40-66 contains a listing of National Military Medical Authority addresses.

c. The MTF commander will be responsible for the decision of suitability for transfer and the arrangements. Final transfer channels should be arranged by local liaison before movement.

d. Patients not suitable for transfer to their own national organizations will be accorded the same treatment and disposition considerations as would apply in the case of a U.S. military member until transfer can be made. This will include processing through the medical evacuation system.

e. Patients not requiring admission to an MTF will be returned to their nearest national organization under arrangements to be made locally.

5-21. Foreign military patients from non-NATO nations

When no disposition instructions are available for such patients, a request for instructions will be forwarded to USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Fort Sam Houston, TX 78234-6010.

5-22. Types of disposition for nonmilitary patients

Dispositions of Federal civilian employees and OWCP beneficiaries are discussed in paragraphs 3-14, 3-15, and 3-24. For other nonmilitary patients, the dispositions shown in a through e below apply.

a. Discharge from the MTF when the patient is released to his or her own custody or custody of the sponsor, NOK, or other authorized persons. (Appointments or instructions for follow-up treatment, if required, are initiated by the attending medical officer.)

b. Transfer to another MTF (para 2-13).

c. Absent without release (when the patient departs without proper release or is otherwise unaccounted for).

d. Release against medical advice. (The patient or other authorized persons will be required to complete DA Form 5009-R (Medical Record-Release Against Medical Advice) as indicated in AR 40-66.)

e. Death.

5-23. Nonmilitary patients mentally ill in a foreign country

a. U.S. military commanders in foreign countries have no authority under either domestic law or international law to

evacuate nonmilitary patients involuntarily. This lack of authority prevails even in medical emergencies when mental illness renders patients dangerous to themselves and others.

(1) The involuntary evacuation of a nonmilitary patient to the U.S. or elsewhere will occur only when the removal has been authorized by authorities of the host government. For persons serving with, or accompanying the Armed Forces or a non-DOD Federal agency, such authorization should be obtained by or with concurrence of the patient's sponsoring service or agency. A nonmilitary person who has been ordered removed may not be evacuated involuntarily except when delivered to proper authorities at the port of embarkation (POE).

(2) In no case will non-U.S. nationals be evacuated involuntarily between countries. An exception is when such evacuation is required by treaty or agreement with the host government, and the patient is delivered to U.S. control at the POE by authorities of the receiving State. Major overseas commanders and the Commander, U.S. Army Forces Command will seek, through the proper U.S. foreign services establishments, to conclude agreements or understanding on procedures to be followed.

b. Before the actual evacuation date of the hospitalized nonmilitary mental patients, the actions in (1) through (5) below will be taken.

(1) Through coordination with the sponsor, if one is involved, and his or her commander or supervisor, determine when the sponsor will depart for the U.S. If the sponsor's departure will be at the approximate time of the family member's evacuation, the sponsor will be advised to immediately report to the gaining MTF in the U.S.

(2) If the sponsor will proceed to the U.S. substantially later than the date of the family member's evacuation, the sponsor must designate the following in writing: the name, address, relationship, and if possible, the telephone number of one relative or another person to act on the sponsor's behalf with respect to the patient. The person designated should be willing to go to the receiving MTF to provide necessary assistance.

(3) A statement should be prepared for the sponsor's signature indicating the sponsor's understanding of his or her responsibilities to the patient. This statement will also reflect the sponsor's present duty station, expected leave address in CONUS, if applicable, and the next duty station or assignment in CONUS, if known. This statement will be in addition to the one required in (2) above and will be obtained regardless of the sponsor's anticipated departure date.

(4) A copy of the statements prescribed by (2) and (3) above will be incorporated in the patient's ITR to aid the receiving MTF in getting any assistance needed.

(5) When a military sponsor is to proceed to the U.S. at a date after the evacuation of the family member, his or her commander will coordinate with the Army Travelers Assistance Center (ATAC) personnel assistance point to notify the gaining MTF commander of the departure date, mode of travel, port of entry, and expected time of arrival in the U.S. When the sponsor arrives, the ATAC will also notify the gaining MTF commander when the sponsor departs the station, the expected time of arrival at the MTF, the interim address where the sponsor may be reached, and any leave or delay en route. The sponsor will be advised to promptly notify the MTF commander of any change in the reported schedule or leave address.

c. After arrival in the U.S., the patient may withdraw the request for hospitalization and request release from the MTF. Disposition will normally be made to proper civilian authorities or, with the approval of those authorities, to the sponsor or NOK. When a nonmilitary patient with a psychiatric condition requires further hospitalization, the MTF commander will contact the sponsor or NOK to ascertain whether the relative wishes to assume the custody and responsibility for the patient's care. The relative will be advised of all factors which render acceptance of the patient inadvisable and of the responsibility in the care of such patient. The relative who accepts responsibility for the patient will present an affidavit declaring his/her willingness to assume responsibility for the patient.

(1) When transfer to the NOK is inappropriate, the MTF commander will contact proper authorities of the State of legal or current residence to obtain authorization to transfer the patient to State custody.

(2) To aid the State authorities in reaching a timely decision they should be provided—

(a) The patient's diagnosis.

(b) The date of onset of the condition.

(c) History of previous hospitalization for mental illness.

(d) Residence.

(e) Place and date of birth.

(f) Name and address of the NOK.

(3) Commitment proceedings or laws for involuntary hospitalization vary among the States. Army MTF personnel must be thoroughly familiar with local requirements for emergency involuntary admission to or retention in local civilian facilities designated for the care of psychiatric patients.

5-24. Evacuation of military spouses from overseas areas to the United States

When a hospitalized military spouse is evacuated from an overseas area to an MTF in the U.S. and is accompanied by a child or children but not by the military sponsor, plans will be made for the care of the children while the parent is

hospitalized. The overseas MTF commander will ensure that plans for the child or children are coordinated with the social worker at the receiving MTF before the family departs from the overseas area.

Chapter 6

Patients in Special Circumstances

6-1. General

This chapter prescribes procedures for preparing and maintaining records pertaining to VSI and SI patients, deceased persons, and patients in certain special categories (SPECAT). It also contains authority for the MTF commander to order autopsies. Notifications required under this chapter are exempt from reports control under provisions of AR 335-15.

6-2. Very seriously ill, seriously ill, SPECAT, (not SI) hospital care required, and (not SI) hospital care not required

a. Definitions. Definitions will be applied literally because international agreements require furnishing information to certain foreign nations concerning VSI and SI patients. The action taken by these nations depends upon which category the patient is placed. (See para 4-7.) VSI, SI, and SPECAT patients will be recorded as part of the DA Form 3821 (Report of Administrative Officer of the Day). DA Form 3821 is available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web (<http://www.usapa.army.mil/>).

- (1) A patient is VSI when the illness is of such severity that life is imminently endangered.
- (2) A patient is SI when the illness is of such severity that there is cause for immediate concern, but there is no imminent danger to life.
- (3) A patient is SPECAT when one of the following conditions exist:
 - (a) Has a severe injury, such as loss of sight or limb.
 - (b) Has a permanent and unsightly disfigurement of a portion of the body normally exposed to view.
 - (c) Has an incurable and fatal disease and has limited life expectancy.
 - (d) Has an established psychiatric condition.
 - (e) May require extensive medical treatment and hospitalization.
 - (f) Has been released from the Service under the provisions of AR 635-40 for a psychiatric condition.
 - (g) Is paralyzed.
- (4) A patient is classified (Not SI) hospital care required and (Not SI) hospital care not required by the hospital commander/physician and reported to the CAC. (Not SI patients are of special interest to the CAC (for example, hostile injuries, multiple or mass casualty (MASCAL) events) (AR 600-8-1). Not SI patient information is provided to the CAC by the patient administrator upon request as it is available.

b. Records (for use in noncombat areas).

(1) *DA Form 2984 (Very Seriously Ill/Seriously Ill/Special Category Patient Report).* When a medical officer determines that a patient is VSI, SI, SPECAT, changes from one category to the other, or subsequently recovers, dies, or is transferred to another MTF, he/she will prepare DA Form 2984 and forward it immediately to the patient administrator, administrative officer of the day, or other designated officer. The MTF commander establishes policy for notification of other persons. Information will be safeguarded against inappropriate disclosures (AR 360-5). All notifications are recorded on DA Form 2984. DA Form 2984 is available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web (<http://www.usapa.army.mil/>).

(2) *Roster of VSI, SI, SPECAT Patients (locally produced).* The patient administrator will prepare on a daily basis a roster of VSI, SI, and SPECAT patients. When automated systems are not available, a manually prepared report should contain the name, grade or status, SSN or other ID number, ward, date first placed on the roster, and present condition. The format of the roster, the method of preparation, and the distribution will be locally determined.

c. Notification procedures in CONUS. Whenever the person to be notified is present at the MTF, the notification will be made immediately by the attending physician (AR 600-8-1).

(1) Upon classification as VSI or SI, the MTF commander will immediately notify the NOK or other person to be notified. A follow-up (progress report) should be sent at least every 5 days and immediately upon a significant deterioration in the patient's condition. A final notification will be sent when the patient is removed from VSI/SI.

(2) When the person to be notified resides in CONUS, notification will be direct by telephonic means. When the person to be notified is not located in CONUS, or notification of NOK is not within the capability of the responsible hospital commander, the casualty information will be relayed immediately to the responsible CAC (AR 600-8-1).

(3) When Army personnel are hospitalized in nonmilitary hospitals, the commander of the MTF administratively responsible for the patient will be responsible for obtaining casualty information and for initiating notification procedures.

(4) A SPECAT patient will be counseled concerning his or her condition and will be encouraged to write personally

when physically and mentally able to do so. When a patient is unable to act in his or her own best interests and cannot communicate with the family, the commander will notify the NOK.

d. OCONUS MTFs. In OCONUS MTFs when the persons to be notified are not locally present, the information will be relayed immediately to the CAC (AR 600-8-1). Notification to the NOK will be accomplished as stated in c above. ITOs may be issued under special circumstances (AR 600-8-1). The OCONUS CAC responsible for the area will be provided casualty information required by AR 600-8-1 and also provided progress reports every 5 days until the casualty is released, recovers, or dies. This information will be used by the CAC to notify the NOK located beyond the hospital (that is, NOK located in another CAC area of responsibility).

e. Notifications pursuant to international agreements.

(1) In addition to all other notification requirements, when personnel of Armed Forces of Allied Nations or foreign national students are patients in CONUS, the MTF commander will provide the CAC information relevant to preparing a casualty report according to AR 600-8-1 and AR 12-15.

(2) The agreement implemented by this paragraph is NATO STANAG 2132.

(3) The ABCA agreement implemented by this paragraph is SOLOG 74.

6-3. Hospitalization of special interest patients and enabling care policy

a. Notifications will be made for admissions, changes in condition (such as major improvement or deterioration of condition, including SI/VSI changes), and disposition from inpatient status including return to duty, discharge, retirement, and death for the following categories of patients:

- (1) General officers.
- (2) VIP patients.
- (3) EC patients.
- (4) MASCAL patients.
- (5) Contingency patients.
- (6) Other special interest patients at the request of higher headquarters.

b. Special interest patients are described in (1) through (5) below.

(1) *General officers.* AD general or flag officers and persons designated to be general or flag officers. Requirements for telephonic notifications to the HQDA (DACS-GOM) must also be met.

(2) *VIP patients.* VIP patients include personnel in (a) through (p) below.

(a) The President of the United States and family members.

(b) The Vice President of the United States and family members.

(c) Former Presidents of the United States and family members.

(d) Cabinet members.

(e) United States Supreme Court Justices.

(f) Congressmen or Congresswomen.

(g) Secretaries of Defense, Army, Navy, and Air Force.

(h) Any former service secretary (authorized care as a retired soldier).

(i) Former Chairmen, Joint Chiefs of Staff and former Chiefs of Staff of Services.

(j) Retired AMEDD general officers.

(k) USAMEDCOM major subordinate commanders.

(l) Foreign heads of states.

(m) Foreign dignitaries.

(n) Retired general or flag officers when placed on SI/VSI roster or upon death in the MTF.

(o) Nationally known figures or celebrities and their family members who, in the opinion of the MTF commander, could be expected to be of particular interest to the Commanding General, USAMEDCOM or the news media.

(p) Any military member assigned to a USAMEDCOM activity upon notification of his/her death.

(3) *EC patients.* EC patients include AD patients who are admitted with any of the potentially disabling medical conditions listed below.

(a) Burns.

(b) Amputations.

(c) SCIs.

(d) Traumatic head injuries.

(e) Eye injuries.

(f) Post traumatic stress disorder.

(4) *MASCAL patients.* MASCALs occur when any number of casualties produced in a relatively short period of time challenge medical and logistical support capabilities. Initial MASCAL reporting requirements to USAMEDCOM, PAD, include incident summary and aggregate casualty/patient information (for example, C-130 training accident with four known deaths all Army, 16 casualties including burns). Follow-on patient specific information, including MASCAL

patients admitted and treated/released (CRO), are reported according to procedures prescribed in a above. These reporting requirements are in addition to any serious incident reports required through USAMEDCOM operational channels.

(5) *Contingency patients.* Contingency patients are generated from contingency operations, such as the deployment to hostile or potentially hostile locations. A contingency patient may be hospitalized within the area of operations or transferred into supporting MTFs (garrison and field). These patients may be evacuated to rear echelon MTFs and are reportable at each MTF.

Note. A single patient may be reportable in several categories, for example, a VIP may be hospitalized as a result of a MASCAL and, if AD, may also be an EC patient. All applicable reporting is still required. For example, when reporting this type of patient, notification to the USAMEDCOM should indicate that the patient is a VIP involved in a MASCAL and a separate EC report will be required.

6-4. Deceased persons

a. All deaths (except civilian emergency) occurring at an Army MTF must be reported to the CAC. A certificate of death is prepared for each deceased person. The MTF commander establishes the policy based upon a need-to-know including those required by AR 600-8-1 and AR 638-2. The CAC must be notified that a mortuary affairs benefits counselor is required to provide mortuary affairs benefit information to the person authorized to direct disposition-of-remains. This briefing must occur prior to requesting a relative of the decedent to complete an SF 523A (Medical Record-Disposition of Body). When the remains are unclaimed, the CAC is responsible for coordinating and taking disposition-of-remains actions as prescribed in AR 638-2. All notifications are recorded on DA Form 3894 (Hospital Report of Death). All information pertaining to deceased notification will be immediately passed to the responsible CAC. Information will be safeguarded to prevent inappropriate disclosure (AR 360-5). The medical officer in attendance at the time of death or in the circumstance of DOA, the medical officer who pronounces a person dead, will initiate DA Form 3894 and forward it, ordinarily by hand carry, to the patient administrator or administrative officer of the day. For stillbirths or fetal deaths within the U.S., DA Form 3894 will be initiated only when a death certification and burial permit are required by local law. For stillbirths or fetal deaths outside the U.S., DA Form 3894 will be initiated only when a death certification and burial permit are required by local law or when the remains will be prepared at an Armed Forces mortuary. The physician in attendance at the time of delivery or abortion is responsible for initiating and forwarding DA Form 3894 to the patient administrator. DA Form 3894 is available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web (<http://www.usapa.army.mil/>).

b. AR 638-2 provides guidance for preparation and disposition of remains and mortuary affairs benefits. DA Form 3910 (Death Tag) is prepared in triplicate and affixed to the deceased (FM 8-230). Local laws of the area in which an MTF is located may impose requirements with regard to handling remains. The MTF commander should obtain disposition of remains guidance from the CAC commander. DA Form 3910 may be obtained through normal distribution channels.

c. Laws governing the registration of stillbirths or fetal deaths (completion of fetal death certificates) vary among the States and overseas countries. Fetal remains will be disposed of according to local law. The disposition desired by the person authorized to direct the disposition of remains will be recorded and will become a part of FN 40-400p (AR 25-400-2). Where the gestational age of the fetus, or weight, in the absence of gestational age information, meets the statutory requirement for death registration, written authorization for disposal of the fetus will be obtained from the person authorized to direct disposition of remains.

d. Disposition of live born infants, regardless of duration of life or gestational age, will be through a licensed funeral director (AR 638-2).

6-5. Autopsy authority and consent

a. The Installation Commanding Officer has statutory authority pursuant to 10 USC 4711, to direct an investigation including ordering an autopsy on persons (military and civilian) found dead on an installation that has exclusive jurisdiction. DOD Directive 6010.16 establishes a system for conducting forensic investigations and authorizes the Armed Forces Medical Examiner at the Armed Forces Institute of Pathology to order an autopsy on an installation that has exclusive jurisdiction (AR 40-57/BUMEDINST 5360.26/AFR 169-99 and AR 600-8-1). Commanders may authorize autopsies performed on the remains of members of the military departments who die while serving on AD or ADT as described in (1) and (2) below.

(1) When considered necessary for the protection and welfare of the military community, an autopsy will be performed to determine the true cause of death or to secure information for the completion of military records.

(2) When death occurs while the member is serving as an aircrew member in a military aircraft, an autopsy is mandatory.

b. In circumstances not covered in a above and except as provided in (1) and (2) below, when an individual dies in an Army MTF or on a military installation, consent from the spouse or NOK must be obtained before an autopsy is performed.

(1) If applicable State laws require the performance of an autopsy, the commander may order an autopsy performed

without the consent of the spouse or NOK. The record will clearly document the authority and reason why consent from spouse or NOK was not obtained.

(2) In overseas areas where local laws and regulations require an autopsy, and the U.S. has not been exempted from such laws or regulations by treaty or agreement, the commander will order an autopsy performed without the consent of the spouse or NOK. The record will clearly document the authority and reason why consent from spouse or NOK was not obtained.

c. In circumstances not covered in a above, when an individual dies outside a military installation and is DOA at an Army MTF, the authority to perform an autopsy is governed by the applicable local laws unless the local authority specifically relinquishes such right, in which case the provisions of b above apply.

d. Authorization or consent for the performance of an autopsy will be recorded on SF 523 (Clinical Record-Authorization for Autopsy). When appropriate, the applicable law, regulation, treaty, or international agreement will be cited as authority and recorded on the SF 523. The servicing SJA or legal advisor should be consulted when necessary (for example, when the definition for "NOK" is needed for the jurisdiction in which the facility is located).

e. All autopsies will be performed promptly to preclude delayed release of remains to mortuary officials. The prosector will comply with restrictions specified on SF 523 or the approving authority. Provided the prosector concurs, embalming may be performed prior to autopsy. All autopsies will be recorded on SF 503 (Clinical Record-Autopsy Protocol).

Chapter 7

Military Personnel Physical Disability Processing

7-1. General

MEBs are convened to document a soldier's medical status and duty limitations insofar as duty is affected by the member's medical status. MEBs must be completed expeditiously. MEB appointments and consultations will receive priority access over all other categories of nonemergent patients. For duty related cases, MEB processing will not normally exceed 30 days (beginning on the date of the medical officer's narrative summary through the date forwarded to the PEB). Military occupational specialty/medical retention board (MMRB) results requiring referral to an MEB should be transmitted expeditiously to the MTF commander (AR 600-60). An MEB should be initiated within 30 days upon receipt of an approved MEB referral from an MMRB. Decisions regarding unfitness for further military duty because of physical or mental disability are prerogatives of PEBs (AR 635-40). MEBs will not express conclusions or recommendations regarding such matters. However, entrance physical standards boards (EPSBDs) will make decisions as to the member's fitness or unfitness for enlistment or induction.

7-2. Appointing authority

MTF commanders; Commander, TSG/Commander, USAMEDCOM; and Commander, 18th MEDCOM; are authorized to appoint MEBs.

7-3. Composition

MEBs will be composed of two or more physician members. One will be a senior medical officer with detailed knowledge of directives pertaining to standards of medical fitness and disposition of patients, disability separation processing, and the Veterans Affairs Schedule for Rating Disabilities (VASRD). It is further encouraged that the physician use the VA Physicians's Guide for Disability Evaluation Examinations to describe the nature and degree of severity of the member's condition. The other member(s) will be familiar with these matters. When a board is considering conditions which normally fall within the professional jurisdiction of the Dental Corps, the membership of the board will include a dentist. Likewise, a board considering a psychiatric problem will include a psychiatrist. In consideration of mental competency, the MEB will consist of at least three members, one of whom will be a psychiatrist.

7-4. Medical board procedures for Medical Corps officers

MEBs will not be done by the MTF to which a Medical Corps (MC) officer is assigned. MC officers may appear before a board at another MTF within their RMC provided the review authority is not in the officer's rating chain. In unusual circumstances, requests for authority to deviate from this policy may be forwarded to USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Fort Sam Houston, TX 78234-6010. A copy of the approval, if granted, will be attached to each copy of the board proceedings. An exception to this policy has been granted to MC officers assigned to Fort Sam Houston, TX as in a and b below.

a. MEBs will be held at Brooke Army Medical Center (BAMC) for all MC officers with duty station at Fort Sam Houston except those assigned to BAMC and USAMEDCOM.

b. MEB officers for MC officers assigned to USAMEDCOM will be appointed by TSG or a designated representative.

7-5. Use of medical evaluation boards

a. Only those patients that present problematical or controversial aspects and those in which MEB action is required by regulation should be referred to the MEB before disposition. Patients who will be returned to duty without any permanent revision to their physical profile and those who require transfer to another hospital before final disposition normally should not be considered by an MEB before such disposition. When patients are transferred, the losing MTF will forward all medical and administrative MEB documents to the gaining MTF having geographical responsibility.

b. Situations that require MEB consideration are—

(1) Those in which PEB referral is contemplated for other than TDRL periodic examinations. (See para 7-21.) It is essential that the MEB evaluate thoroughly and report all abnormalities and their impact on fitness for duty. Correlation must be established between the abnormalities and the inability to perform duties. This is particularly important when a chronic condition is the basis for referral to a PEB and there has been no change in the severity of the condition.

(2) Those involving patients with medical conditions or physical defects that are usually progressive in nature and expectations for reasonable recovery cannot be established. The MEB must ensure that adequate documentation is made of the nature, extent, and cause of all medical conditions or physical defects in question.

(3) Those involving patients whose medical fitness for return to duty is questionable, problematical, or controversial. When a member's fitness for further military duty is questionable, it becomes essential that all abnormalities in his or her condition be thoroughly evaluated. Under these conditions, evaluation will be undertaken only in an MTF that has the necessary professional staffing and equipment. Also, the MTF must have the administrative competence and experience to document the case fully and to initiate the member's processing. Otherwise, the member will be transferred to the nearest Army MTF that has the capability.

(4) Those involving RC personnel on authorized duty—

(a) Whose fitness for further military service upon completion of hospitalization is questionable.

(b) Who require hospitalization beyond the termination of their tour of duty.

(5) Those involving an RC member not on AD who require evaluation because of a condition that may render him or her unfit for further duty. If the condition is the result of injury incurred while on authorized duty for 30 days or less, the case may be referred to a PEB as provided in paragraph 7-21. RC members with a disabling condition incurred under other circumstances will be processed under provisions of AR 40-501. RC personnel with a nonduty related condition pending separation for medical disqualification are entitled to a PEB.

(6) Those involving ROTC members on a training tour (annual training camps and training encampments at military installations)—

(a) Who may be eligible for benefits under the OWCP because of an injury incurred or a disease contracted during their training tour (para 5-9 and AR 145-1).

(b) Who require hospitalization beyond the termination of their training tour.

(7) Those involving mental competency.

(8) Those involving persons scheduled for separation under AR 600-8-24 and AR 635-200 when it appears that a mental illness, medical condition, or physical defect is the direct cause of unfitness, unsuitability, or homosexual delusions. Referral into the disability evaluation system takes precedence over enlisted administrative separations except where the regulatory provisions authorize a discharge characterized as Under Other Than Honorable Conditions. Officers pending administrative separations are generally dual processed.

(9) Those involving persons who are being considered for expeditious discharge under AR 635-40. This also includes personnel who request waiver of the PEB evaluation for non-service aggravated, pre-existing conditions.

(10) Those deemed necessary by the appointing authority.

c. As required, the responsible MTF will use an MEB to determine mental competency of any military member who is hospitalized in a non-Federal facility. The Departments of the Navy, Air Force, and VA are authorized to determine mental competency of retired Army members when such persons are hospitalized in a facility under their jurisdiction.

7-6. Sanity boards

A sanity board consists of one or more medical officers and is convened according to Rule 706, Manual for Courts-Martial, 1995 edition (Misc Pub 27-7), to inquire into the mental condition of an accused. Findings of the sanity board concerning the person's sanity, including specific answers to the questions posed in Rule 706, will be submitted in writing to the parties concerned. The members of the board will be furnished all facts and circumstances of the incident or occurrence that led to convening the sanity board. This will include a copy of the investigation conducted under UCMJ, Article 32. Officers serving on sanity boards may be physicians (preferably psychiatrists) or licensed clinical psychologists. At least one member must be a psychiatrist or a clinical psychologist. Licensed psychologists are included on sanity boards so that they can provide appropriate tests and evaluations-different from psychiatric evaluations-to determine the mental competency or responsibility of the accused. The selection of officers to be appointed to a sanity board is the responsibility of the MTF commander who should decide, based on the individual

case and on the differences between psychiatric and psychological examinations, which of the two disciplines (if not both) should be represented on the sanity board.

7-7. Medical evaluation board proceedings

MEBs operate informally and may assemble to discuss and evaluate the patient's case. Clinical, health, and other records, as appropriate, are reviewed. If deemed appropriate and when a patient's condition permits, the patient may be given the opportunity to appear in person and present their views relative to the proposed disposition. Medical fitness standards are contained in AR 40-501 for military members and for ROTC members.

7-8. Recording proceedings

a. MEB proceedings will be recorded on DA Form 3947 (Medical Evaluation Board Proceedings). DA Form 3947 is available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web (WWW.usapa.army.mil). The following general instructions apply in the completion of DA Form 3947: A brief, but complete, clinical history prepared by the patient's attending physician on SF 502 will be attached to the board proceedings as enclosure 1. This will include a summary of available prior medical records and information from the HREC and the SF 88 prepared at the time of entry into Service.

(1) For patients with a mental disorder, regardless of etiology, include a statement indicating whether the patient is—

- (a) Mentally competent for pay purposes.
- (b) Capable of understanding the nature of, and cooperating in, PEB proceedings.
- (c) Dangerous to himself, herself, or others.

(2) For psychiatric illnesses considered to have begun or existed at the time of entry into the Service, include in the narrative summary all available clinical and social data concerning the conditions of the patient's entry into Service. The summary should also show significant behavior and the patient's attitude toward the Army and toward the act of entry into Service. It should also include data upon which to base a judgment on whether or not the patient was mentally competent to understand the nature of the act of entry into Service. If the patient is considered to have been incompetent to understand the act of entry into Service, then the clinical data should show the subsequent date when the patient did become competent to understand the nature of this act. If the patient never became so competent, clinical data should be sufficient to support this opinion.

(3) When an EPTS condition is judged to be aggravated by service, the severity and circumstances will be clearly indicated in the narrative summary.

(4) A complete, current report of medical examination will be included in the narrative summary completed by the physician and recorded on SF 502.

(5) When an enlisted member is being evaluated because of a psychiatric condition, a copy of DA Form 2-1 (Personnel Qualification Record-Part II) should be reviewed by the MEB and attached to the board proceedings as enclosure 3.

(6) For patients who are unlikely to return to duty, the member's commander will be contacted and asked to provide a special letter of evaluation which describes the member's recent duty performance. This letter will be evaluated by the MEB and attached to the board proceedings as enclosure 4.

b. Except as required elsewhere in this regulation, copies of DA Form 3947 and enclosures will be distributed as shown in table 7-1. If mental incompetency is found, one additional copy will be prepared for the U.S. Army Finance and Accounting Center. (See para 7-13.) All MEB members will sign the original and initial duplicate copies of the proceedings. However, if mental incompetency is found, all copies must be signed by each member. The copy of SF 502 that becomes part of the medical record will be annotated by the attending physician to show final disposition of the patient. The original DA Form 3947 is the hospital copy of record.

c. MEBs referred to a PEB require special care in recording MEB proceedings to ensure clarity and completeness. PEBs usually evaluate an individual's impairments primarily on the basis of the records. Review and appeal boards use only the records and never see the patient. It is imperative, therefore, that entries be worded carefully so that they are both informative and precise. The entry on SF 502 describing the patient's present condition should include an accurate description of the limitations imposed by each impairment listed. If applicable, the entry should also include a discussion of the combined effect of all impairments.

7-9. Preparation of DA Form 3947

The following instructions apply to preparation of DA Form 3947:

- a. Items 1 through 11. Obtain from personnel or medical records.
- b. Item 12. Check applicable box.
- c. Item 13. List all diagnoses in descending order of significance. For cases being recommended for referral to the PEB, note applicable paragraph in AR 40-501.
- d. Item 14. Check the applicable box. If the MEB finds the soldier qualified for retention but requires duty limitations, list all limitations. DA Form 3349 must always be attached. Patients whose medical condition(s) and

physical defect(s) meet the criteria of AR 40-501 will be recommended for referral to a PEB. MEBs on all soldiers referred to the PEB must include an updated DA Form 3349 which lists all duty limitations.

e. Items 15 and 16. Check the appropriate box. If continuation is requested and it is medically feasible, indicate assignment limitations and profile in item 30.

f. Items 17 through 19. When a board member must be qualified in a specific medical specialty, enter the specialty after name and grade.

g. Items 20 through 22. Check the appropriate boxes. If either item 20 or 21 is checked, the approving authority will attach an enclosure stating the reason for return or referral.

h. Item 23. The MTF commander may delegate approving authority to a senior MC staff member with detailed knowledge of directives pertaining to standards of medical fitness and disposition of patients, disability separation processing, and the VASRD.

i. Item 24.

(1) If the patient is located in the vicinity of the MTF, he or she will be advised of the approved findings by the physical evaluation board liaison officer (PEBLO) and asked to check the appropriate box. If the patient disagrees with the findings, he or she will be asked to prepare a statement citing reasons for disagreement. The statement will be attached. The patient is authorized 3 working days to decide his or her election. Extensions of time beyond 3 working days may be granted for reasonable cause such as desire to consult with legal counsel, and so forth. If the patient does not make an election, the case will be forwarded as if approved by the member. Refusal or inability on the part of the patient to make an election will require an explanatory note in the board proceedings.

(2) When the patient is not at the MTF, a certified letter will be sent by the MTF advising the member of the board's recommendations and requesting a written reply indicating his or her agreement or disagreement. A copy of the complete MEB report will be attached to the letter. The letter will indicate that the member has 3 working days following receipt of the letter to forward his or her election to the MTF. Extensions of time beyond 3 working days may be granted for reasonable delays. MEB processing, receipt of the soldier's election and forwarding to the PEB is completed at the originating MTF. If the member does not make an election, the case will be forwarded as if approved by the member. Refusal or inability on the part of the patient to make an election will require an explanatory note in the board proceedings.

j. Item 25. Self-explanatory.

k. Items 26 through 29. For use by the approving authority when acting on a patient's request for reconsideration. If the case is returned to the MEB for reconsideration, the board's action will be attached, in narrative form, as an enclosure to the report. Any further action by the approving authority will be referenced in item 30 and will be specified in an attachment.

l. Item 30. For use when continuing entries or for remarks. Identify continuations by the number of the appropriate item in DA Form 3947.

7-10. Documentation for referral to a physical evaluation board

Documentation required as attachments when MEB proceedings require referral to a PEB is as follows (refer to AR 635-40 for the list of additional documentation):

a. A complete current medical examination (examinations less than 6 months old if no major change has taken place in the patient's medical condition). These reports will be attached as enclosures to the MEB board proceedings and will be recorded on SF 88 and SF 93.

b. Copies of all previous MEBs and PEBs. Medical record copies of civilian medical records, and x ray films will be retained in the HREC by the MTF until requested by the PEB. (All medical records will accompany any disability case referred to the PEB involving a general officer or MC officer.)

c. The HREC with a copy of entrance history and medical examination when required by the PEB. For MEBs on psychiatric diagnoses, the HRECs will include the psychiatric treatment records.

d. A copy of the request for VA treatment facility bed designation or a copy of orders moving the patient to a VA treatment facility for continued hospitalization, if applicable.

e. A copy of correspondence to State authorities for disposition of psychiatric members who are not eligible for hospitalization in a VA treatment facility, if applicable.

7-11. Expeditious discharge

Soldiers who are identified within the first 6 months as not meeting the medical procurement standards under AR 40-501, chapter 2, may be separated under AR 635-200. The soldier is not referred to the PEB. Soldiers who have a condition listed in AR 40-501, chapter 3, and the condition is deemed pre-existing and nonservice aggravated may be separated under AR 635-40 without evaluation by the PEB if the soldier requests waiver of the PEB evaluation.

a. Enlisted soldiers that do not meet AR 40-501, chapter 2 standards but do meet AR 40-501, chapter 3 standards are processed as follows: DA Form 4707 (Entrance Physical Standards Board (EPSBD) Proceedings) is used for recording EPSBD proceedings. DA Form 4707 is available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web (<http://www.usapa.army.mil/>). The soldier must be on their initial enlistment and the EPSBD

condition identified within the first 180 days of enlistment. These proceedings apply only to those enlisted personnel who within the initial 180 days of AD or ADT are found to have a medical condition/physical impairment which, had it been identified, would have precluded their current induction or enlistment (AR 40-501) however, their medical condition/impairment is within retention standards (AR 40-501, chap 3). Additionally, the condition has not been permanently aggravated during any period in which the member was entitled to base pay.

b. Officers are evaluated under AR 40-501, chapter 3 only and must be referred to an MEB/PEB if they fail to meet retention standards.

c. EPSBD chapter 2 procedures include—

(1) A member will be referred for EPSBD action when there is clinical evidence, written documentation, or patient admission in conjunction with a clinical history, that the medical condition, had it been identified, would have precluded the member's induction or enlistment. This condition must be noted within the initial 180 days and recorded in an official military record (for example, medical/unit records).

(2) Soldiers who have entered AD with a medical waiver for a disqualifying condition will not be separated for that condition under these provisions.

(3) All medical records applicable to the member will be reviewed. The primary purpose of this board is to document those EPTS medical conditions which would have precluded induction or enlistment but were not noted during the entrance physical examination. Additionally, this board will note any changes in the member's physical condition since his/her entitlement to base pay. Patients undergoing EPSBD action will be processed on an outpatient basis except when active inpatient treatment is required.

(4) Proceedings will be recorded on DA Form 4707.

d. Instructions for the preparation of DA Form 4707 include—

(1) Items 1 through 7. Obtain from personnel or medical records.

(2) Item 8. In narrative form, the evaluating physicians will provide the following information:

(a) General statement of health (compare the induction medical examination with the member's current condition noting all changes and/or discrepancies). Attach a copy of entrance medical examination.

(b) Specific history of medical conditions/impairments noted as changes to and/or discrepancies in the information contained in the entrance medical examination.

(c) Current clinical and laboratory findings (positive and negative), as required.

(d) List of all diagnoses. Note paragraph and subparagraph of AR 40-501.

(3) Item 9. Enter correct profile (and assignment limitations, if appropriate).

(4) Items 10 and 11. When an evaluating physician/dentist is qualified in a specific medical specialty, enter the specialty after grade and sign.

(5) Items 12 through 15. Check the appropriate box. If the approving authority disapproves a case or returns it to the boarding physician, the reason will be stated in writing in the continuation section on reverse. If more space is needed, attach an 8 1/2- x 11-inch sheet of paper to DA Form 4707.

(6) Item 13. The MTF commander may delegate approving authority to a senior MC staff member to review and act on EPSBD. Such a person (for example, the DCCS) is knowledgeable of both MEB procedures and AR 40-501. This individual cannot participate in the EPSBD as a member, witness, consultant, or in any capacity other than approving authority.

Note. This board does not require a new physical examination. The entrance examination will be attached. However, soldiers must be given a separation examination if they request one.

(7) Items 16 through 20. These are used to refer DA Form 4707 from the MTF commander to the member's commander for appropriate action. Items 18 and 19 may be executed for the commander by a duly appointed adjutant/assistant adjutant.

(8) Items 21 through 24. The member's commander will counsel the soldier as to his/her right including the opportunity to consult with an attorney, either military or civilian, if desired, prior to making a decision. (Consulting with a civilian attorney will be at no expense to the Government.) The commander will ensure that the soldier understands the options available. The member is authorized up to 3 working days to decide on his/her election. Extension of time beyond 3 working days may be granted by the unit commander for reasonable delays (for example, to consult with legal counsel). The member will indicate his/her selection by initialing the appropriate box in item 21. If the member requests retention on AD, the member will state his/her reasons for desiring retention. This statement will be attached to the DA Form 4707. If the member disagrees with the medical findings and requests reconsideration, the medical evidence will include copies of medical records/statements from physicians. Medical disagreements will be referred to the medical approving authority for resolution while retention disagreements will be referred to the unit commander for resolution.

(9) Items 25 through 28. These are used as action by unit commander.

(10) Items 29 through 32. These are used as action by discharge authority. (AR 635-200 applies.)

(11) Continuation. Identify continued items by item number.

e. When the patient appeals, the medical approving authority will reconsider the case with the submitted medical evidence.

(1) If the evidence reveals that the member was fit for enlistment, the case will be returned to the evaluating physicians/dentist directing an appropriate profile (and assignment limitation, if appropriate). Written justification for the revision of the EPSBD will be attached as an addendum.

(2) If the evidence reveals that the member was not fit for enlistment, these boards will be returned to the unit commander with a confirmation of the original finding. The EPSBD will attach an addendum confirming the finding.

f. Dispositions will be disseminated as follows:

(1) Original and one copy to unit commander.

(2) One copy to member.

(3) One copy to HREC.

g. Upon final action by the discharge authority, a copy of the finalized DA Form 4707 will be forwarded to—

(1) U.S. Army Recruiting Command, ATTN: RCCS-SURG, Fort Knox, KY 40121 for review and appropriate action.

(2) The medical facility, ATTN: PAD, for coding under the Individual Patient Data System (IPDS).

7-12. Medical evaluation board approving authority

a. The appointing authority is also the approving authority for MEB proceedings. He or she will not participate in the proceedings, either as a member, witness, consultant, or in any other capacity. MEB proceedings and all addenda thereto will be reviewed by the approving authority and his or her action recorded. When the findings and recommendation are approved, the recommended disposition will be effected at the earliest practicable date. If the approving authority does not concur with the board's findings or recommendations, the proceedings will be returned to the board for further consideration. If the findings or recommendations of a board which has reconsidered a case are not approved, the approving authority will forward the board's proceedings, in duplicate, together with appropriate recommendation, to the chief surgeon of the overseas command or the appropriate RMC commander as applicable, for final decision.

b. The approving authority may delegate authority to review and act on MEBs. The individual to whom this authority is delegated (for example, DCCS) must not participate in the board proceedings either as a member, witness, consultant, or in any other capacity.

7-13. Distribution of medical evaluation board proceedings

Distribution of board proceedings will be as indicated in table 7-1. Distribution will depend on the disposition of the patient and on conditions further prescribed for RC and ROTC personnel in paragraph 5-9, for prisoner patients in paragraph 5-13, and for certain military personnel requiring further hospitalization upon separation in paragraph 5-18. Additional copies prepared for mentally incompetent patients will be forwarded directly to U.S. Army Finance and Accounting Center, ATTN: DFAS-IN-FJEC-B Settlement Operations, Indianapolis, IN 46249-0845.

7-14. Interservice cooperation in medical evaluation board actions

a. MEB proceedings of one Uniformed Service are acceptable to another Uniformed Service and may serve as a basis for further medical or administrative action by that Service.

b. Soldiers who are hospitalized in MTFs of another Uniformed Service capable of providing the required medical care will not be transferred to an MTF of his or her parent Service merely to fulfill an MEB convening requirement. The MEB will be convened at the MTF where the patient is hospitalized and the report of proceedings will be forwarded to the reviewing authority of the soldier's Service for appropriate action.

c. Soldiers who require aeromedical evacuation to another MTF and who are not expected to return to duty will be regulated and moved to the MTF nearest the member's home which is capable of providing the required care and disposition. The losing MTF will immediately notify the MTF with geographical responsibility for the soldier. This is normally done without regard to the member's Service affiliation. However, patients in the categories in (1) through (3) below will be evacuated to a hospital of the parent Service.

(1) Those who are undergoing dual processing such as medical disability and administrative separation or court-martial proceedings.

(2) Those who require special psychiatric examinations to determine competency to receive pay.

(3) Service academy cadets.

7-15. Triservice medical evaluation board coordination

a. To ensure that administrative control is maintained for Air Force, Navy, and Marine Corps members hospitalized in Army hospitals, personnel of the admitting (Army) hospital will immediately notify the closest Navy or Air Force hospital. It is the responsibility of the Navy or Air Force hospital to assume administrative control of their patients. For example, when an Air Force member is hospitalized at Darnall Army Community Hospital, Fort Hood, personnel at Darnall should immediately notify Wilford Hall Medical Center.

b. MEB proceedings completed by another Uniformed Service may include recommendations regarding the member's disposition. However, "referral of the proceedings to the Service reviewing authority" is the only official disposition that can be used. This is required since Service physical standards vary and could result in different dispositions. Also, one Uniformed Service will not commit another Uniformed Service to a specific disposition.

c. The member's Service may request another MTF where the member is hospitalized to initiate proceedings. While such requests are not binding or mandatory, every effort will be made to honor them.

d. The PEBs of all Uniformed Services are authorized to communicate directly with the hospital that convened the MEB when additional or clarifying information is needed.

e. If difficulties arise between two MTFs which cannot be resolved at that level, assistance should be requested through Service headquarters channels.

f. Questions concerning another Service's medical standards will be referred to the appropriate Service reviewing authority.

7-16. Options available to the Service reviewing authority

If an MEB prepared by another Service is forwarded to the member's Service reviewing authority, the reviewing authority may—

a. Accept the board proceedings and process according to Service directives.

b. Return the proceedings to the MEB appointing authority for further information or clarification.

c. Reject the board proceedings and direct the transfer of the member to a hospital of his or her parent Service for further evaluation if it is deemed to be in the best interest of the patient and the Service concerned.

7-17. Counseling members concerning medical board results

a. Upon completion of the MEB and approval of the proceedings, the member will be counseled concerning the findings. If the member disagrees with the board, the member has 3 working days to prepare a written appeal for submission to the appointing authority. If no action is taken by the member within 3 working days, the board results will be forwarded, as if approved by the member, to the Service reviewing authority for further action.

b. After approval by the Service reviewing authority and a disposition is recommended, the member will be advised of the proposed disposition. The member will be afforded the opportunity to appeal the decision of the reviewing authority. The member will ordinarily have 3 working days in which to submit an appeal.

7-18. Transmittal of medical evaluation board proceedings by Service reviewing authority to Service physical evaluation boards

The reviewing authority will attach the completed board proceedings to a letter of transmittal. This letter will state the proposed service disposition and state that the member has been advised and agrees or disagrees with the proposed disposition.

7-19. Processing actions related to physical evaluation boards

a. The PEB results will be forwarded directly to the MTF where the patient is located. An informational copy will be provided to the appropriate Service reviewing authority.

b. Counseling on PEB findings will be the primary responsibility of the member's parent Service. However, PEBLO counseling arrangements may be established by mutual agreement between the appropriate Service reviewing authority and the MTF where the member is hospitalized when it is beneficial to do so.

c. TDY funding for appearances at formal PEB hearings will be the responsibility of the member's parent Service. For Army patients, this is the soldier's unit of assignment.

7-20. VA Physician's Guide for Disability Evaluation Examinations and the VASRD

Medical officers who prepare MEBs for presentation will be familiar with the VA Physician's Guide for Disability Evaluation Examinations and the VASRD. Material contained in these documents is essential in the disability evaluation process.

7-21. Referrals

a. Soldiers in the following categories will be referred to a PEB:

(1) Regular and RC members with LD disabilities who fail to meet retention standards as outlined in AR 40-501, chapter 3. This includes those who apply for continuance on AD under AR 635-40. AR 635-40 contains instructions for commanders on the referral of persons to the PEB. RC members who do not meet medical retention standards for a condition incurred or aggravated while performing duty of 30 days or less or those pending separation for medical disqualification for nonduty related conditions that request a fitness determination by a PEB. (Also see National Guard regulation (NGR) 40-400 and AR 135-381.)

(2) All members on the TDRL following their periodic medical examination.

b. The Deputy Chief of Staff for Personnel (DCSPER), on advice of TSG, DA, may direct referral of a case to a PEB for adjudication.

7-22. Referral to the physical evaluation board liaison officer

Members will be referred to the PEBLO as soon as it has been determined that referral to a PEB may be recommended. Referral to the PEBLO is also proper when the member is undergoing a TDRL periodic examination and related evaluation according to AR 635-40. No members will be told that they will be discharged or retired from the Service or told the percentage of their disability until PEB results are finalized.

7-23. Records sent to a physical evaluation board

When a case is referred to a PEB, all pertinent records will be sent to the board by the fastest means available. AR 635-40 addresses records and other administrative requirements for PEB adjudication.

7-24. Preparing medical evaluation board narrative summaries

The recommended format for an MEB narrative summary is provided below.

a. *Baseline documentation.* At the beginning of the MEB, the following will be recorded:

- (1) The signatory physician's specialty.
- (2) The clinical department/service.
- (3) The MTF and its location.
- (4) Reason for doing the MEB (for example, physician-directed, command-directed).
- (5) Soldier's eligibility for MEB.
- (6) Military history.
 - (a) Date of entry into Service.
 - (b) Estimated termination of Service.
 - (c) Administrative actions ongoing, pending, or completed (for example, courts-martial, selective early retirement, bars, retirement or separation dates).
- (7) Chief complaint stated in soldier's own words.
- (8) History of present illness. Exact details, including pertinent dates regarding injuries, how incurred, and a statement of the final LD determination, if available.
- (9) Past medical history.
 - (a) Past injuries and illnesses.
 - (b) Prior disability ratings (for example, given by the VA).
 - (c) Past hospitalizations and relevant outpatient treatment, including documentation of diagnosis and therapy, pertinent dates, and location should be listed.
 - (d) Illnesses, conditions, and prodromal symptoms, existing prior to service conditions.

b. *Physical examination.* A complete physical examination must be recorded in the MEB. Selected specialty-related considerations and guidelines follow.

- (1) *Cardiology.*
 - (a) Results of special studies to support and quantify the cardiac impairment should be noted (for example, treadmill and thallium stress tests, angiography, and other special studies).
 - (b) It is imperative that the Functional Therapeutic Classification of the cardiac condition be included. Either the New York or Canadian classification system may be used.
- (2) *Gastroenterology.* Soldiers with fecal incontinence should have recorded findings of rectal examination (for example, digital exam, manometric studies as indicated and radiographic studies). The degree and frequency of the incontinence should be noted, as well as the incapacitation caused by the condition.
- (3) *Neurosurgery.*
 - (a) In vertebral disc problems, radicular findings on physical examination should be supported by laboratory studies such as computerized axial tomography scan, MRI, or electromyography. In cases where surgery has been performed, both pre- and post-operative deep tendon reflexes should be documented.
 - (b) In head injuries, neuropsychiatric assessment should be accomplished. Results of any clinically indicated neuropsychological testing should be included.
- (4) *Ophthalmology.* If retention standards are not met for reasons related to vision, visual fields must be included in the physical examination and verified by an ophthalmologist. Specialist examination should include uncorrected and corrected central visual acuity. Snellen's test or its equivalent will be used and, if indicated, measurements of the Goldman Perimeter chart will be included.
- (5) *Orthopedics.*
 - (a) Range of motion measurements must be documented for injuries to the extremities. The results of the measurement should be validated and the method of measurement and validation should be stated.

(b) In cases involving back pain, the use of Waddell's signs should be included in assessing the severity and character of the pain. (See app A.)

(6) *Psychiatry.*

(a) Particular attention should be paid to documenting all prior psychiatric care. Supportive data should be obtained for verification of the patient's verbal history.

(b) Psychometric assessment should be carried out if such assessment will help quantify the severity of certain conditions and allow a reference point for future evaluation.

(c) The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised (or current edition) will be used for diagnostic terminology (app A). The Multiaxial System of Assessment will be used to include Axes I-V. The degree of social and industrial impairment must be determined and documented, and correlated to the soldier's clinical manifestations for each Axis I and Axis II diagnosis. In addition, relationship of the impairment to military and civilian performance is required.

(d) Every effort must be made to distinguish symptoms and impairment resulting from personality disorder or maladaptive traits from impairments based on other psychiatric conditions.

(7) *Pulmonary.* When an MEB is held for restrictive or obstructive pulmonary disease, documentation will be provided of pulmonary function testing carried out when soldier is on and off therapeutic medication. There must be three pulmonary function tests done off medication, two of which must be in agreement within the 5 percent level, and three done on medication, two of which must agree within the 5 percent level.

(8) *Urology.*

(a) Cases involving neurogenic bladder must have studies done that document the condition.

(b) All cases involving incontinence must have studies done that document the condition.

(c) Cases involving incontinence/neurogenic bladder should have documentation regarding severity as indicated by the number of times self-catheterization is required, the number and type of pads required in a day, or the soilage frequency.

c. *Laboratory studies.* Studies that support and quantify the diagnosis(es) should be included as should any studies that conflict with the diagnosis(es).

d. *Present condition and current functional status.* The current clinical condition of the soldier should be noted including required medications and any non-medication treatment regimens (for example, physical therapy) in progress.

(1) The soldier's functional status as to the ability to perform his/her required duty should be indicated.

(2) The soldier's civilian equivalent performance should be indicated.

(3) A statement should be given regarding the prognosis for functional status after completion of treatment, if chronic treatment is not necessary.

(4) A statement should be given regarding the prognosis for functional status in cases requiring chronic treatment.

(5) The stability of the current clinical condition and functional status should be addressed.

e. *Conclusions.*

(1) An informed opinion should be stated as to the soldier's ability to meet current retention standards.

(2) If a soldier does not meet retention standards, the specific reasons why should be stated.

f. *Diagnosis(es).* The diagnostic terminology used by the MEB should correlate, if at all possible, with that of the VASRD. Because the PEBs are required to assess a soldier's status based on the VASRD, a clearer understanding of that status is facilitated when the same terminology is used by the MEBs and the PEBs. All MEB diagnoses will be given an International Classification of Diseases-Ninth Revision-Clinical Modification (ICD-9-CM) code.

g. *Profile (if required by Service regulation).*

(1) The physical profile of the soldier should agree with the severity of the medical impairment as expressed in the narrative summary.

(2) The physical profile of the SF 88 should agree with that of the physical profile form, as well as that noted in the MEB cover sheet.

Table 7-1
Distribution of medical board proceedings (See notes 1 and 2)

| Type of Disposition | Health Record Copy No. | Clinical Record Copy No. | Hospital Copy No. | Other Copy No. |
|---|------------------------|--------------------------|-------------------|---|
| 1. Returned to duty | 1 | 2 | 3 | |
| 2. Retained under medical jurisdiction for later evaluation | 1 | 2 | 3 | |
| 3. Referred to physical evaluation board | | 7 | 8 | 1 through 6 to PEB |
| 4. Separation not for disability: | | | | |
| a. Release from AD RC | 1 | 2 | 3 | |
| b. Discharge | 1 | 2 | 3 | |
| 5. EPTS separation not referred to PEB | 1 | 2 | 3 | 4 copy of SF 88 and SF 93 attached to Cdr U.S. Army Recruiting Command ATTN: RCCS-SURG, Fort Knox, KY 40121. (See AR 635-40.) |

Notes:

¹ See AR 635-40 for disposition of DA Form 3947 when a disabled individual is continued on AD.

² See AR 40-501 for instructions on the use of DA Form 3349 to notify unit commanders of physical profile and assignment limitations on members returned to duty.

Chapter 8

Medical Holding Unit

8-1. General

Each MTF having inpatient capabilities, except those functioning in a contingency zone operation, will maintain an MHU company/detachment. Patients that do not meet the medical criteria of this chapter are not attached or assigned to the MHU. Military personnel are not attached or assigned to the MHU for compassionate reasons.

8-2. Notification of admission and discharge

a. The patient administrator of an MTF where a patient is first admitted will immediately notify the commander of the patient's unit. The notification will include the time and date of admission. Another notification is made when the patient is returned to duty or another disposition is made.

b. When a patient is admitted while en route overseas, the patient administrator will notify the ATAC. The patient administrator will indicate the probable length of hospitalization and whether the patient is expected to be assigned to the MHU. (See para 8-4c.)

8-3. Attachment of AD Army personnel to a medical holding unit

a. All AD Army patients admitted directly or by transfer are attached to the MHU. The CHCS automated AAD report is authorized for use as the attachment order.

b. When an AD Army soldier is admitted to an other-than-Army MTF, the Army MTF having geographic responsibility will place the soldier in the status of absent sick. The MHU will prepare an attachment order and forward it to the soldier's assigned unit and the MTF at which the soldier is hospitalized.

c. AD Army inpatients attached to an MTF may be referred to another MTF for short-term treatment and returned to the originating MTF. This may include referral of a patient from an overseas MTF to a CONUS MTF at the discretion of the overseas MTF commander.

d. Attachment to an MHU for soldiers in an outpatient status is only authorized when the MTF commander/physician determines that continuous treatment is required and that the soldier cannot be managed by his or her unit. That is, the MTF is not located within daily traveling distance to the soldier's unit.

8-4. Assignment of AD Army personnel to a medical holding unit

AD Army soldiers may be assigned to an MHU in an inpatient or outpatient status. The MHU will issue assignment orders.

a. While assigned to the MHU, the patient may undergo further treatment, convalescence, subsisting out (see para 5-

7), and start MEB processing. While in an assigned outpatient status, patient progress will be monitored and the patient will be added to the medical hold/patient squadron roster when appropriate.

b. Unit commanders will ensure that soldiers undergoing disability evaluation processing are available for all necessary MEB/PEB processing. Soldiers should not be assigned to medical hold unless they meet one of the requirements in c below. MTF commanders are not authorized to enter into agreements to automatically assign members to the MHU while undergoing physical disability processing. Soldiers will normally receive MEB/PEB processing on an outpatient basis while assigned to their parent organization. Assignment to the MHU will not be used to facilitate the early requisitioning of replacement personnel. Rather, members undergoing physical disability processing are to contribute to mission accomplishment at the parent unit to the degree possible.

c. Patients will be assigned to the MHU as in (1) through (7) below.

(1) Upon evacuation from a combat area to an MTF maintaining an MHU.

(2) When or as soon as the MTF commander determines that a patient will be hospitalized in excess of 90 days. The 90-day period refers to the total period of continuous hospitalization; it is not limited to a specific MTF.

(3) Upon hospitalization in a VA treatment facility with SCIs or brain injuries, or other long-term care requiring PEB action, these patients will be assigned to the MHU of the responsible Army MTF. They will then be processed as a PCS to the VA treatment facility. The Army MTF having administrative responsibility will provide accountability, clinical monitoring, and final administrative processing of the patient until fit for duty and reassigned or separated from Service.

(4) When an overseas MTF commander determines that a patient exceeds the theater length of treatment practices or requires special services not available and must be evacuated and not returned to duty.

(5) When the MTF commander determines that a patient, whose unit or numbered shipment is scheduled for more than a local move, will not be returned to duty before the date of departure of the unit or numbered shipment. If so, within proper security limits, commanders of such units or numbered shipments will keep the MTF commander advised of the expected date of departure.

(6) When the MTF commander determines that—

(a) A patient en route overseas will require hospitalization over 30 days beyond his or her scheduled reporting date.

(b) A patient hospitalized at an MTF serving an aerial POE will require hospitalization over 30 days beyond his or her normal shipment date. The reporting date will be computed and established per AR 600-8-105. Distribution of orders will be according to AR 600-8-105. Care will be taken so that all organizations having personnel accountability for the patient are included. A patient transferred from one Army MTF to another in an assigned status will be carried in an assigned status by the receiving MTF.

(7) When outpatients do not require inpatient care and are unable to perform even limited duty at their assigned unit.

d. The following patients are ineligible for assignment to an MHU:

(1) Members of the other Uniformed Services, if hospitalized in an Army MTF, require tracking and reporting to the applicable Service.

(2) Special RC program personnel (AR 600-8-6) may not be assigned.

(3) Personnel assigned to a CONUS organization who are hospitalized while temporarily in an overseas command may not be assigned. If such personnel will be evacuated to CONUS, they will be evacuated in an attached status.

(4) General officers will not be relieved from duty assignment and assigned to MHUs without the approval of the DCSPER, HQDA.

(5) Military personnel who are under investigation, courts-martial charges or sentence, nonjudicial punishment, or administrative separation proceedings—other than those authorized by AR 635-40—will not be assigned from a local unit without concurrence of the MHU commander and PAD chief.

8-5. Individual records and clothing

a. Personnel and pay records of patients attached to an MHU will be kept in the patient's assigned organization. The MTF commander may request copies of records required for the study and evaluation of a patient.

b. When reassignment orders are issued, a copy of the order is sent immediately to the soldier's prior organization to expedite receipt of personnel and pay records.

c. When the servicing military personnel officer receives a reassigning order, the soldier's personnel and pay records will be forwarded to the MTF within 5 working days (AR 600-8-104). Individual clothing will be sent according to AR 700-84.

8-6. Return to duty of attached patients

a. Attached patients may be returned to duty or duty with profile limitations after hospitalization.

b. Attached patients enroute overseas at the time of admission will—

(1) If preparation of replacements for overseas movement (POR) qualified, be furnished a statement of the period of hospitalization and directed to the installation port call/transportation movements office.

(2) If no longer POR qualified, will be reported for assignment instructions according to paragraph 8-8. The ATAC serving the aerial POE will be notified of the action taken.

8-7. Disposition of assigned patients in CONUS

a. Except as provided in b below, all patients who are medically fit for duty and assigned to an MHU will be reported by the MTF commander for assignment instructions. (See para 8-8.)

b. Upon discharge from the hospital, patients in the categories described in (1) through (6) below will be reassigned by the MTF commander without reporting to PERSCOM.

(1) Persons who, when hospitalized, were undergoing basic combat training or advanced individual training and who are hospitalized in the MTF serving the installation where training was interrupted will be reassigned to their former training activity.

(2) Persons who are medically fit for duty under AR 40-501 but will be returned to duty with a recommendation for separation (para 5-3e(1)) will be reassigned to their former units. The MTF commander may make exceptions to this policy if it is determined that other action will better serve the interests of the Government. Reassignment instructions will be requested per paragraph 8-8 or separate action may begin at the MTF.

(3) Persons awaiting trial by courts-martial will be reassigned to their former units or to the unit or installation where the trial will be held. The local SJA or legal officer will be consulted.

(4) Persons awaiting the results of investigation or clearance will be reassigned to their former units if a request for this action has been made by the commander concerned. Normally, patients will not remain assigned to an MHU solely to await the results of these actions. If assignment instructions cannot be obtained, the person will be placed on duty as outlined in paragraph 8-9.

(5) Persons eligible under existing criteria for release from AD or discharge will be processed at the MTF if facilities exist. If not, processing will be according to AR 635-10.

(6) Officers medically fit for duty who have applied for or are scheduled for retirement within 60 days or who have submitted a tender of resignation will remain assigned to the MHU until instructions are received from PERSCOM. The MTF commander will promptly report such officers to Commander, PERSCOM (TAPC-PDT-R), Alexandria, VA 22332-0400. If the officer has appeared before an MEB, a copy of the board proceedings will accompany the report. When practicable, officers awaiting instructions under this subparagraph will be placed on duty according to paragraph 8-9.

8-8. Requests for assignment instructions

When a patient is to be returned to duty, the MTF commander or his or her designated representative will request assignment instructions. The request will be sent to PERSCOM not later than 15 days before the estimated date of discharge from the hospital. All MTF commanders are responsible for monitoring the progress of assigned patients. MTF commanders will make every effort to render an accurate forecast of the expected date of return to duty. This is necessary to avoid delay in returning a patient to duty. (AR 614-100 contains officer and warrant officer assignment policies and AR 614-200 contains enlisted personnel assignment policies.)

a. The following information will be included in requests for duty assignments for officers other than general officers and warrant officers:

(1) Name, grade, and SSN.

(2) Branch of Service for Judge Advocate General's Corps and Chaplain Corps officers, corps for AMEDD officers, and control branch for others.

(3) Category and expiration date.

(4) Amount of leave desired, if any.

(5) Estimated date of completion of hospitalization.

(6) Physical profile and assignment limitations, if any.

b. Enlisted personnel will be reported to PERSCOM according to instructions in AR 614-200.

c. In exceptional circumstances, it may not be possible to predict the date of return to duty within the 15-day time requirement. Assignment instructions will be requested from PERSCOM through the most expeditious means available.

d. When a patient is to be returned to other than full duty, the request for assignment instructions will state the type of disposition recommended. It will also contain the following information as appropriate:

(1) The date on which the person will revert to full duty or the date of return to an MTF for examination, treatment, or reevaluation.

(2) The type and degree of functional impairment involved and any control measures which should be considered in a duty assignment.

(3) The type(s) of duty recommended.

(4) Geographic or climatic assignment limitation recommended.

(5) Physical limitation to POR qualification.

(6) Status of any applications for compassionate reassignment submitted under AR 614-100 for officer personnel and AR 614-200 for enlisted personnel.

(7) Whether current medical condition may result in removal or denial of security clearance.

(8) Patient's preference for area of assignment.

e. When a person cannot be assigned as directed within 30 days after the previously estimated date of completion of hospitalization, this information will be sent by electrical message, facsimile, or other electronic means to the office that issued the assignment instructions. The message will include a reference to the initial request for assignment instructions.

8-9. Duty for assigned patients awaiting orders in CONUS

a. Assignment instructions may not have been received when a patient is released from the hospital. In this case, the MTF commander will issue orders attaching the patient to duty with a unit designated by the installation commander. When this is not medically sound, the MTF commander may place the person on duty with the MTF duty unit. (See AR 635-40.) Such a person will not be charged against the MTF personnel allotment or manning table.

b. CONUS installation commanders will designate (regardless of command jurisdiction) a unit where the MTF commander may place patients on duty where their abilities can be used. Preferably, these units will be other than MTFs, but will be located as near to the MTF as possible.

8-10. Disposition of patients in overseas MTFs

A recovered patient in an overseas MTF will be returned to duty under instructions issued by the major overseas commander. For MTFs in Alaska and Hawaii, instructions will be issued by the member's major commander.

8-11. Separation of enlisted personnel assigned to medical holding units

AR 635-200 addresses special separation provisions.

8-12. Disposition of Reserve Component personnel

RC personnel hospitalized when their orders are for 30 days or less will not be assigned to the MHU, but can remain in the MTF in a patient status and draw pay and allowances; they will not be on AD (AR 135-381). RC soldiers on AD orders for 31 days or more may be extended on AD upon recommendation of their physician.

8-13. Performance of duty while in patient status

AD soldiers may be assigned temporary duties in and about the MTF or in a unit or local post when such duties do not interfere with their availability for medical care requirements. Physical condition, past training, and acquired skills must all be considered before assigning any patient to a given task. Patients will not be assigned duties outside the limits of their physical profile (AR 40-501).

8-14. Prolonged definitive medical care for AD military patients who are unlikely to return to duty

Prolonged definitive care is not provided for AD soldiers who are unlikely to return to duty. The time at which a patient should be processed for disability separation must be determined on an individual basis. The interests of both the patient and the Government should be considered. The long-term patient roster generated by CHCS will be used by the MTF utilization managers to monitor the progress of patients undergoing prolonged definitive treatment. This roster lists all inpatients with 30 or more continuous days of hospitalization. In addition, the MTFs utilization management committee (AR 40-68) will also be provided a separate roster for the management of medical hold patients not in an inpatient status and for all patients undergoing MEBs at the MTF.

Chapter 9

Administration of Patients in Non-Army MTFs

9-1. Care in Navy and Air Force MTFs

Army military personnel may be provided medical care subject to access as determined by the Navy and Air Force MTF commander. Patients are eligible for care as defined in chapter 2 subject to the rules of the Navy or Air Force MTF commander.

9-2. General policies applying to care in Navy and Air Force MTFs

Army military personnel hospitalized in Navy and Air Force facilities are not also admitted to Army MTFs. Personnel accountability is managed as specified in paragraph 8-3b. Collection of subsistence charges from Army officer patients, hospitalization charges from Army family members, and charges for other categories of patients is made locally by the Navy or Air Force MTF.

9-3. Army administrative units at Navy and Air Force MTFs

When the Service concerned concurs, an MTF commander may establish, from available resources, Army administrative units in Navy and Air Force MTFs. Army administrative units coordinate directly with Navy and Air Force MTF staff. An Army administrative unit stationed at a Navy or Air Force MTF is assigned to the Army MTF having geographical area responsibility for Army patients located at the Navy or Air Force MTF.

a. Command authority.

- (1) Army administrative staff comply with station orders or regulations of the Navy or Air Force MTF.
- (2) The Army administrative unit performs MHU functions. (See chap 8.)
- (3) Army personnel at a Navy or Air Force MTF will be subject to the military authority of the Navy or Air Force commander, but may be assigned or attached to the Army administrative unit for administration. Military control of such personnel normally will be exercised by the Navy or Air Force commander through the commander of the Army administrative unit.

b. Supervision and support. Army MTF commanders supervise and provide required logistical and administrative support to Army administrative units.

c. Navy or Air Force MEBs. Such MEBs are used in lieu of an Army MEB. (See paras 7-14 through 7-16.)

d. Military discipline.

(1) The commander of an Army administrative unit may have authority under the UCMJ, Article 15 to impose nonjudicial punishment upon those Army members assigned or attached subject to the provisions of the UCMJ, Article 32.

(2) With the consent of the Navy or Air Force commander, Army prisoner patients may be transferred into and out of Navy or Air Force MTFs under either Army guard or the guard of the Service concerned. Local Navy or Air Force confinement facilities may be used with permission of the Navy or Air Force commander for temporary confinement of Army personnel.

e. Autopsies and professional inspections.

- (1) Navy or Air Force medical officers may make professional inspection of deceased Army personnel as required.
- (2) The Navy or Air Force commander may direct that autopsies be performed on the remains of Army military personnel when such procedures are necessary to find the true cause of death and to acquire information to complete military records. Such autopsies, including microscopic examination of tissues, may be performed by Navy or Air Force medical officers per TM 8-300/NAVMED P-5065/AFM 160-19. Copies of autopsy protocols will be filed with the permanent records of the Army administrative unit.

f. Funds. The Navy or Air Force MTF procedures to safeguard patient funds and valuables will be used.

9-4. Care in Federal MTFs other than those of the Uniformed Services

Personnel listed in this paragraph may be provided medical care subject to access as determined by directors of Federal facilities. Patients are subject to the same limitations identified in chapter 2 and any additional rules of the Federal facility concerned.

a. Members of the Army, RC, and applicants identified in paragraphs 3-1 through 3-8.

b. Retired Army members. Retired Army members (see paras 3-9 and 3-10) placed on the TDRL may be furnished required medical examinations at VA treatment facilities upon DA request. Inpatient and outpatient medical and dental care for nonservice-connected disabilities may be provided in VA treatment facilities on a space-available basis as Army beneficiaries.

c. Civilians interned by the Army. Such individuals will be provided hospitalization in Armed Forces MTFs (AR 190-57) only in the absence of adequate civilian facilities. (See para 3-38.)

d. Other categories of beneficiaries. Other categories of beneficiaries may be treated in other Federal facilities. However, the patient administrator will coordinate with the receiving facility prior to referral to ensure care is authorized according to that Federal facility's rules of care and that reimbursement methodologies are acceptable to the Army MTF commander.

9-5. Authorization

DA Form 4159 (Request for Medical Care in a Federal Medical Treatment Facility Outside Department of Defense) is used to authorize care in Federal MTFs for Army beneficiaries. A commander may authorize care for a soldier under his or her command when required in a Federal MTF. DA Form 4159 is prepared in triplicate and is addressed to the officer in charge of the Federal MTF in which care is desired. The patient presents the original and one copy of the form to the MTF when applying for treatment. In an emergency, care may be furnished without such a request; however, DA Form 4159 should be forwarded after the event. DA Form 4159 is not required for active and retired Army members. Identification will be made by DD Form 2A (ACT) or DD Form 2 (RET) (United States Uniformed Service Identification Care (Retired)). DA Form 4159 is available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web site (www.usapa.army.mil)

9-6. Use of Federal medical treatment facilities for supplementation

When it is necessary to use the services of other Federal MTFs to supplement Army MTFs or MEPS, commanders may obtain such services upon their written request direct to the officer in charge of the Federal MTF concerned. Vouchers for these services will be sent to the facility requesting the services and paid from local operating funds.

9-7. Reimbursement to other Federal facilities

Vouchers for care furnished by Federal MTFs will be prepared by the agencies concerned. They will be sent (supported by copies of DA Form 4159, when appropriate) to Commander, USAMEDCOM, ATTN: MCRM-F, 2050 Worth Road, Fort Sam Houston, TX 78234-6000 for settlement with the following exceptions.

a. Vouchers for services incurred by applicants identified in paragraphs 3-4 through 3-8 will be settled by the MEPS requesting services. Emergency medical care for acute illnesses and injuries identified in paragraph 3-8 are forwarded to Commander, USAMEDCOM, ATTN: MCRM-F, 2050 Worth Road, Fort Sam Houston, TX 78234-6000.

b. Vouchers for quadrennial medical examinations of USAR personnel will be forwarded to the appropriate MCS contractor.

c. Vouchers for medical examinations performed for members and prospective members of the RC will be paid by the State concerned.

d. Vouchers for services obtained for DA Federal civilian employees addressed in paragraph 3-14 will be settled locally by the organization arranging for the occupational health services.

9-8. Special consideration of Uniformed Services Family Health Plan beneficiaries

Uniformed Services beneficiaries enrolled in the Uniformed Services Family Health Plan (USFHP) (see fig 9-1) managed care plan are not eligible beneficiaries at Army MTFs except for emergencies or until disenrolled. AD Army personnel are not eligible for the USFHP.

9-9. Administration of patients treated at Federal MTFs other than the Uniformed Services and civilian facilities

Army MTF commanders are responsible for coordinating the care of AD Army patients treated at Federal MTFs other than the Uniformed Services and at civilian facilities. Major Army medical commanders are assigned GARs. The listing of GARs can be found at the Army Medicine web site (www.armymedicine.army.mil). When AD Army general officers are admitted to or released from Navy, Air Force, or other Federal or civilian MTFs, the MTF assigned administrative responsibility will follow procedures specified in paragraph 6-3. When an AD Army member is admitted to a non-Army MTF or placed in quarters by a nonmilitary physician, the appropriate Army MTF commander will—

a. Provide necessary professional medical evaluation and assistance. If the patient is receiving care from a civilian agency, a physician at the responsible Army MTF will promptly contact the attending civilian physician to determine the patient's condition and the feasibility of evacuation to an MTF.

b. Notify the patient's parent unit except when notification has already been accomplished.

c. Provide strength accounting, pay and allowances, and other personnel functions for patients assigned to an MHU and needed personnel functions except pay and allowances for patients attached to an MHU. (See chap 8.) These functions will be accomplished even though the patient is not physically located within the Army MTF having administrative responsibility. Army members hospitalized in Navy or Air Force MTFs are accounted for and substantiated by Navy or Air Force AAD reports or other similar documents.

d. Arrange transfer between MTFs by Government or commercial transportation and authorize further necessary travel upon completion of hospitalization.

e. Prepare the following when care is provided in other than an Armed Forces MTF:

- (1) ITR and appropriate HREC entries (AR 40-66).
- (2) Patient accountability as required in chapter 8.
- (3) SI and death notification required in AR 600-8-1.
- (4) Initiation of LD actions when appropriate.
- (5) Third party liability processing when appropriate. (See chap 13.)
- (6) Assess the need for an ITO for the NOK of a soldier listed as VSI or SI.

f. Have administrative responsibility for patients excused from duty for medical reasons including—

- (1) Required clinical evaluation and assistance.
- (2) Notification to the patient's parent unit.
- (3) Arrangement of transfer by Government or commercial transportation to another MTF when required.
- (4) Preparation of the following when care is provided in other than an Armed Forces MTF:
 - (a) HREC entries (AR 40-66).
 - (b) SI and death notifications (AR 600-8-1).
 - (c) Initiation of LD actions when appropriate.

Johns Hopkins Medical Service
Corp
Wyman Park Drive
Baltimore, MD 21211

Brighton Marine Public Health
Center
77 Warren Street
Boston, MA 02135

Sisters of Charity of the Incar-
nate Word
2600 North Loop West
Houston, TX 77092

St John's Hospital
2050 Space Park Drive
Nassau Bay, TX 77058

St Joseph's Hospital
1919 LaBranch
Houston, TX 77002

St Mary's Hospital
3600 Gates Boulevard
Port Arthur, TX 77642

Pacific Medical Center
1200 12th Avenue South
Seattle, WA 98144

Bayley-Seton Hospital
Bay Street and Vanderbilt Avenue
Staten Island, NY 10304

Martin's Point Health Care Cen-
ter
331 Veranda Street
Portland, ME 04103

Lutheran Medical Center
2609 Franklin Boulevard
Cleveland, OH 44113

Figure 9-1. Uniformed Services Family Health Plan locations

Chapter 10 Care From Civilian Sources

10-1. For whom authorized

When appropriate care cannot be provided by MTFs, care from civilian sources may be authorized for personnel in a through g below, subject to limitations specified in chapter 2 and this chapter. Provisions of this chapter apply to soldiers who are assigned to a remote location or traveling in areas where there is no MTF, other Federal MTF, or TRICARE.

- a. Members of the Army, RC, and applicants identified in paragraphs 3-1 through 3-8. (Note additional approvals required in para 3-2d.)
- b. Prisoners of war, retained personnel, and other personnel in military custody or confinement. (See para 3-38.)
- c. Hospitalization in Armed Forces medical facilities of civilians interned by the Army only in the absence of adequate civilian facilities (AR 190-57).
- d. Civilian seamen in the services of vessels operated by the DOD. (See para 3-41.)
- e. Civilian employees of the Army limited to those occupational health services authorized in AR 40-5.
- f. Retired Army TDRL personnel that require hospitalization in order to complete medical examination. (In this case, civilian care is paid through the MTFs operating funds.)
- g. U.S. nationals confined in foreign penal institutions (para 3-57).

Note. Retired uniformed soldiers are not provided civilian medical care under the provisions of this chapter. Subject to the rules in paragraph 2-3, retired members and family members are authorized civilian medical care under TRICARE or the Supplemental Health Care Program (SHCP).

10-2. Qualifications of professional personnel engaged to furnish medical care

- a. *Qualifications of clinicians.* Only appropriately certified and/or licensed clinical personnel will provide services to patients authorized care under this chapter. This includes doctors of medicine, doctors of osteopathy, doctors of dentistry, podiatrists, optometrists, physician assistants, nurse practitioners, and nurse midwives. Clinicians must have valid licenses to practice their specialties in a State, a territory of the U.S., the District of Columbia, or the Commonwealth of Puerto Rico. Nurses must be currently registered to practice nursing in a State or territory of the U.S., the District of Columbia, or the Commonwealth of Puerto Rico.

(1) In overseas areas, except the Commonwealth of Puerto Rico, licensing and registration criteria will be as prescribed by the major overseas medical commander concerned.

(2) Services of emergency medical technicians (EMTs) may be authorized even though the injured soldier is not transported to the hospital by ambulance. The EMT must be licensed by that State to provide the specific care rendered.

b. Restrictions.

(1) Except as indicated in (2) below, only those licensed or registered professional personnel covered in a above can be used for medical services if payment is to be made from Army funds.

(2) Practitioners specializing in the sciences allied to the practice of medicine who are licensed to practice in the area concerned may be used for medical services under (1) above when such service is provided on the written request of a licensed doctor of medicine, osteopathy, or dentistry as part of the medical care required.

(3) Payment is not authorized for the following services:

(a) Christian Science services.

(b) Acupuncture services

10-3. Special considerations for AWOL members receiving civilian medical care

a. Civilian medical care will not be authorized for members who have sought asylum in foreign countries. Charges for emergency civilian medical care of AWOL members will be covered under the SHCP. When information concerning the treatment and whereabouts of such a member is received, the nearest provost marshal will be notified so that action may be taken to effect actual return of these personnel to military control.

b. Medical care for RC personnel is specified in paragraph 3-2.

10-4. Apprehended members of the Army who are confined or committed by civil authorities

a. Medical treatment for members who are confined or committed by civil authority is the responsibility of that detaining authority until such time as custody of members is relinquished to the military services or members are released to continue their status before apprehension.

b. Charges for medical services provided during the period of confinement or commitment will not be paid from SHCP funds unless it can be substantiated that the initial request for detention was made by an official of the Federal Government.

c. When requests for payment under the above circumstances are received, a determination must be made as to what medical treatment was received during the actual period of civil confinement or detention. Treatment received prior or subsequent to actual detention by civil authorities or during a period of detention initially requested by an official of the Federal Government is the responsibility of the Army and should be processed for payment.

10-5. Approving authorities

The TRICARE PCM or MCS contractor's health care finder acts as the approving authority for soldiers enrolled at an MTF.

10-6. Authorization for civilian medical care

a. Except as indicated in c below, personnel will not obtain care from civilian agencies without obtaining prior authorization from the designated approving authority.

b. In TRICARE Prime areas, procedures for obtaining prior authorization for all non-emergent medical care will be provided by the PCM. Direct contact with the approving authority may be necessary to obtain prompt approval for time sensitive medical care. If requested medical care is authorized, coordination of that care will be maintained by the Army MTF for the patient. (See chap 8.)

c. Individuals may obtain civilian medical care without the prior authorization of the designated approving authority under the following conditions:

(1) In emergencies when the urgency of the situation does not permit obtaining such prior authorization as defined in e below.

(2) When the individual is serving OCONUS.

(3) When an AWOL individual is undergoing emergency civilian care as specified in paragraph 10-3.

(4) For remotely stationed soldiers as defined in e below.

d. When civilian medical care is obtained without prior authorization, the patient's immediate commander will advise the appropriate approving authority without delay that such care is being or has been obtained so that the approving authority may further coordinate the soldier's medical needs. When a soldier is hospitalized in a civilian MTF while on leave, pass, PCS, or TDY from their station, it is the individual soldier's responsibility to notify (or to have someone notify in their behalf) the nearest Army MTF or their commander who must notify the appropriate Army MTF.

e. In areas designated as remote, instructions for obtaining medical care through the TPRP and the SHCP can be found at the TRICARE/DOD Health Affairs web site (<http://www.tricare.osd.mil/>).

10-7. Dental care in civilian facilities for active duty personnel

Instructions for requesting dental care in civilian facilities for active duty personnel can be found at the Military Medical Support Office web site (<http://navymedicine.med.navy.mil/mmso/>).

10-8. Autopsies

The commander or the surgeon of an installation or command may authorize autopsies to be performed by civilian physicians, civilian laboratories, or at civilian MTFs to determine the true cause of death and to secure information for the completion of military records.

10-9. Rates of compensation

The rates of compensation paid for outpatient claims are at the CHAMPUS maximum allowable charge (CMAC). AD inpatient claims are priced using DRG methodology. When soldiers have paid the billed amount for properly authorized care, reimbursement will be for the amount paid. In cases where the civilian provider seeks reimbursement from the soldier for any excess unpaid by the MCS contractor, exceptions to the CMAC/DRG based pricing may be made. TRICARE managed support contractors establish rates for payment of civilian medical claims within their areas of responsibility.

10-10. Payment of civilian medical claims

For instructions on payment of civilian medical claims, see the TRICARE/DOD Health Affairs web site (<http://www.tricare.osd.mil/>).

10-11. Medical records and reports

a. When an AD soldier receives inpatient care at a civilian facility, the patient will be accounted for as “absent sick” by the MTF having geographic responsibility for the area in which the patient is hospitalized. ITR and HREC entries will be made according to AR 40-66. For patients whose medical records are maintained at another MTF (for example, for soldiers traveling on leave, TDY, etc.), the HREC documentation will be forwarded to the responsible MTF by the MTF carrying the patient as “absent sick.”

b. Reasonable charges may be paid to civilian physicians or civilian MTFs for furnishing copies of medical records, reports, and studies when such services have been requested by the patient administrator.

Chapter 11

Medical Services Accounts

11-1. Policies

The policies in a through e below apply to all fixed MTFs and table of organization and equipment (TOE) facilities furnishing medical care on a reimbursable basis to eligible personnel. (See chap 2 and app B.)

a. If the volume of medical care furnished on a reimbursable basis at the MTF does not warrant the establishment of a separate medical services account (MSA) (for example, U.S. Army health clinics with a small volume of pay patients), the MTF commander may request an exception to the provisions of paragraphs 11-2 through 11-13 from the MACOM commander.

b. MACOM commanders are authorized to grant an exception to establishing a separate MSA, if warranted, to MTFs under their command jurisdiction.

c. Granting an exception to paragraphs 11-2 through 11-13 does not constitute a waiver of requirements to bill and collect monies due. All accounting procedures specified in this chapter and in the Medical Services Account Users' Manual will be followed.

d. The MSA accountability must be transferred when a MSAO is relieved or replaced. (See para 11-6 and fig 11-1.)

e. When the MSA is to be discontinued, the MSAO must make a discontinuance statement. (See para 11-7 and fig 11-2.)

11-2. Medical services accountable officer appointment

Each commander of fixed MTFs will appoint an MSAO by written orders. The MSAO may be a commissioned officer, warrant officer, or civilian employee, not otherwise accountable for appropriated funds or Government property. However, responsibility for property or custodianship of nonappropriated funds will not prevent appointment.

11-3. Medical services accountable officer deputy appointment

The MSAO may request, by written order, a deputy to assist with the MSA administration. The Deputy MSAO must

qualify under the MSAO criteria as stated in paragraph 11-2. During the MSAO's absence (not to exceed 30 days), the deputy will assume the duties of the MSAO. If the MSAO's absence exceeds 30 days, the facility commander will appoint a replacement.

11-4. Assistant medical services accountable officers

Military and civilian personnel will assist the MSAO with the MSA functions. The MSAO will designate MSA personnel as cashiers. These persons will be assigned on either a full- or a part-time basis.

11-5. Emergency relief of the medical services accountable officer

When the MSAO must be replaced under conditions such as death, incapacity, or for cause, the installation or facility commander will immediately appoint a disinterested officer to—

- a. Count the MSA cash on hand.
- b. Transfer the accountability to the newly appointed MSAO by performing the steps given in paragraph 11-6.
- c. Follow procedures in paragraph 11-11 if shortage is found. The new MSAO will assume accountability subject to an adjustment for any shortage.

11-6. Transfer of medical services accounts accountability

When the MSAO is being relieved or replaced, the MSAO will—

- a. Ensure that all transactions to the time of transfer are posted to the MSA accounts and records are adequately documented.
- b. Ensure that all cash collections on hand are deposited to the servicing Defense Account Office (DAO).
- c. Verify the change fund in the presence of the relieving officer and arrange for the transfer of accountability with the servicing DAO.
- d. Prepare a listing of all unused controlled forms.
- e. Complete the MSA accounts and records according to month-end procedures.
- f. Prepare and complete a statement (in quadruplicate) transferring MSA accountability to the relieving officer using the format shown in figure 11-3. The new custodian will complete a statement (in quadruplicate) as shown in figure 11-4. Retain the first copy and distribute the signed statements as follows:
 - (1) Original to the MSA files.
 - (2) Second copy to the relieving officer.
 - (3) Third copy to the facility commander.

11-7. Medical services accountable officer discontinuance statement

On receiving authority to discontinue an MSA, the MSAO will—

- a. Ensure that all charges accrued through the discontinuance date are computed and that DA Form 3154 (MSA Invoice and Receipt) or an automated bill is prepared, posted, and presented to, or forwarded to the patients or sponsors.
- b. Ensure that all transactions occurring through the discontinuance date are shown on the MSA records and properly documented.
- c. Deposit all collections on hand through the date of discontinuance.
- d. Collect the change fund from the cashier(s) and return it to the servicing finance and accounting office (FAO), which will issue a receipt for personal records.
- e. Complete all reconciliations according to month-end procedures.
- f. Transfer current account and related documents to the servicing FAO.
- g. Include the original of the MSAO discontinuance statement (see fig 11-2) with records transferred to the servicing FAO.
- h. Retain a duplicate MSAO discontinuance statement for personal record.
- i. Prepare, complete, and sign a discontinuance statement in duplicate, to be signed by the servicing FAO and approved by the facility commander. The format shown in figure 11-2 will be used. When an automated system is being used, request disposition instructions for stored data tapes from higher headquarters.

11-8. Change fund

The MSAO will submit a written request to the installation or facility commander to establish a reasonable change fund for the MSA. On approval by the installation or facility commander, funds may be advanced to the MSAO by the servicing DAO or self generated by collections. Accountability for MTF change funds is the responsibility of MTF treasurers. Change funds may be established by advancing funds specifying the MTFs appropriation at the beginning of each FY and refunding the appropriation at the end of the FY. To accomplish this—

- a. Complete SFs 1034 and 1034A advancing funds to the change fund administrator.
- b. Utilize operating funds and element of resource 4140.

- c. Allow the change fund administrator to decide the dollar amount issued to the change fund.
- d. Ensure that the change fund balances never fluctuate and that the balances remain constant.
- e. Ensure that the closing SFs 1034 and 1034A cite the same funds as the beginning FY SFs 1034 and 1034A. Credit the appropriation, deposit the funds, and clear the advance. Repeat this process each consecutive FY.
- f. AR 37-103 takes precedence over all other regulations in the areas of change fund control and accountability. The MSAO may separate the change fund by hand receipt only as necessary to operate the MSA; that is, a portion of an existing change fund can be advanced to an individual by the use of a hand receipt. This hand receipt must be secured by the change fund holder each time a portion of the existing change fund is advanced. This hand receipt must be cleared daily by the change fund holder. This is not legal authority for the MSAO to issue a change fund from a change fund.

11-9. Automation

The MSAO will use the approved automated systems of automatic data processing procedures prescribed and forms generated by CHCS or other approved automated MSA subsystems when the capability exists. (See DOD 7000.14-R, Volume 1 for guidance.) Forms required for use with manual systems include DA Form 3153 (Medical Services Account Patient Ledger Card), DA Form 3154, DA Form 3155 (MSA Cash Record), DA Form 3929 (Accounts Receivable Register and Control Ledger), DD Form 7, and DD Form 7A. DA Form 3153 is available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web (<http://www.usapa.army.mil/>). DA Form 3155 and DA Form 3929 may be obtained through normal distribution channels.

11-10. Audit and review

The MSA is subject to audit and review under AR 11-7, AR 36-2, and AR 36-5.

11-11. Physical loss of medical services accounts funds

Monies accepted from patients as payment for services are considered MSA change fund until deposited with the supporting FAO or a designated banking facility. If physical loss of funds from the MSA change fund occurs, the MSAO will—

- a. Immediately notify the supporting DAO.
- b. Notify the MTF commander, in writing, within 24 hours, of all known facts about the loss. Notify USAMEDCOM, ATTN: MCRM-F, 2050 Worth Road, Fort Sam Houston, TX 78234-6000 within 48 hours of all known facts about the loss. If the supporting DAO/operating location is not located within commuting distance, notify the USAMEDCOM within 24 hours.
- c. Follow procedures in AR 37-103 on loss of funds.

11-12. Reports

Month-end accounting procedures for automated systems will use the output of the CHCS MSA subsystem.

11-13. Charges

Persons not authorized care in Army MTFs by law or regulation will be charged the applicable “others” rate. (See app B and the Medical Services Account Users’ Manual.)

11-14. Application of charges

The application of charges is subject to guidance issued by the OASD(HA). This guidance allows certain operating requirements unique to DOD MTFs. Local judgment will apply in determining whether a charge is proper. If a medical charge is proper, it cannot be waived, suspended, compromised, or settled by the MTF commander. The DFAS has this authority within the DOD. Such authority was given to the DFAS by the Secretary of Defense under the Federal Claims Collection Act of 1966, 31 USC 3711. Charges of \$100,000 or more require Government Accounting Office approval and will be considered by DFAS for forwarding to Government Accounting Office.

a. *Inpatient.* The inpatient rates are all inclusive and are based upon guidance issued by the OASD(HA). No additional charges will be applied.

b. *Outpatient.* DOD MTFs may provide health care services to some categories of non-entitled patients (for example, DOD civilians overseas) on a reimbursable basis. Reimbursement will be calculated according to rates established by the Under Secretary of Defense (Comptroller). All separate outpatient visits during a single day will result in a separate charge for each visit. Failing to charge for each visit received during the same day means that the facility will not recover the full cost of services rendered. The only exception to this rule is when a patient visits the same clinic multiple times in the same day. In this case, they are charged for one visit at the rate for that clinic.

(1) Follow-up visits on subsequent days are chargeable unless the sole purpose of having the patient return is to verify the success of the previous treatment and no additional treatment is provided.

(2) The following services, whether initial or follow-up visits, are not chargeable:

- (a) Check-in at “sick-call” to make an appointment for a visit on a subsequent day.

- (b) Prescription refills. (New prescriptions of controlled drugs obtained without the patient seeing a doctor are considered refills.)
 - (c) Consultation and advice on the results of vaccinations and tests such as the tuberculosis TINE and pap smear.
 - (d) Physical therapy treatments.
 - (e) Telephone discussions. Telephone discussions which do meet the criteria of a clinic visit are not chargeable. This does not apply to telephone consultations which are considered visits and are, therefore, chargeable.
 - (f) Weight checks.
 - (g) Blood pressure checks requested by the physician as a follow-up treatment.
 - (h) Check of bandages, casts, etc.
 - (i) Removal of sutures.
 - (j) Vision tests for drivers' licenses.
 - (k) Verification of physical profile series.
 - (l) Dependent school children's visits to public health nurses who are located at the school and who are employees of the medical facility.
- (3) When dental is available, each sitting, not each procedure, is normally a chargeable visit. Exceptions to this policy apply when dental examinations and cleaning are performed. These procedures are normally intended to occur in a single sitting. The fact that workload or other factors preclude performing both procedures in one sitting does not justify an additional charge to the patient. Also, patients should not be charged for follow-up dental care which is required solely for the following:
- (a) Postoperative treatment.
 - (b) Occlusal adjustments.
 - (c) Denture adjustments.
 - (d) Tissue conditioning treatments.
 - (e) Treatments following surgical, periodontal, and endodontic procedures to promote healing or to verify recovery.
- (4) If a patient visits both a medical clinic and the dental clinic on the same day, two outpatient visit charges will apply unless—
- (a) The visit to the medical clinic qualifies as a nonchargeable visit under b above.
 - (b) The visit to the dental clinic was medically directed by the attending physician for dental care adjunctive to the medical treatment.
- (5) Although a per case or per shot rate is established for immunizations when given in conjunction with a chargeable outpatient visit, no extra charge will be made for each shot or dose. Smallpox and other vaccinations, therapeutic or desensitization (allergy) injections, and TINE tests for tuberculosis are considered immunizations.
- (6) Group treatments or evaluations in schools, community centers, isolated locations, or in the MTF are not chargeable as individual outpatient visits. Group rates, however, will be calculated to cover the actual costs of services rendered. Such treatments or evaluations include—
- (a) School, sports, and other similar examinations.
 - (b) Group therapy sessions and group activity counseling such as prospective parents' classes, group instruction in first aid, and dental or oral hygiene classes.
- (7) Services provided under the Occupational Health Services Program for the U.S. employees will be supported without charge to the individual employee.
- (8) Care provided to DOD civilian employees, which is covered under the OWCP, is not charged to the patient. Non-DOD civilian employees are billed for health care received in MTFs even if it is job related.
- (9) Patients admitted and discharged on the same day by an inpatient medical facility will not be charged the outpatient rate. Rather, they will be charged the appropriate inpatient or ambulatory patient visit rate.
- (10) Confidential medical care and advice provided adolescent family members of Federal civilian employees at authorized teen clinics and youth health centers will not be chargeable.
- (11) Public health measures will not be charged when the area military commanders, upon recommendations of their principal medical staff officer, determine that such measures are required in the interest of the health of the area. Public health measures include those services that are recognized and accepted by health authorities as preventing the spread of communicable, environmental, and industrial diseases, and reducing the common risk to a given disease. Included are—
- (a) Immunizations prescribed by health authorities.
 - (b) Interview, examination, and follow up of close contacts with tuberculosis, venereal disease, meningococcal meningitis, viral hepatitis, and other communicable diseases.
 - (c) Detection and treatment of drug, alcohol, and other substance abuse.
 - (d) Biological tests associated with epidemiological surveys.

11–15. Chargeable medical examinations and immunizations

The applicable outpatient rate or the immunization rate will be charged for examinations or immunizations furnished other than in connection with inpatient or outpatient care. (See app B.)

11–16. Use of credit cards for payment

Credit cards may be accepted for payment when the credit card system used does not result in a surcharge to the Government.

11–17. Billing and reporting procedures

In complying with instructions in this regulation, forward reports of medical service and billing documents to the authorizing organization. The appropriate address will be used.

11–18. Negotiable instruments

The MSA is responsible for all negotiable instruments received by the activity. All negotiable instruments must be endorsed, “For deposit to the Treasury of The United States” upon receipt. All negotiable instruments will be deposited within 24 hours or the next business day in the supporting DAO or a designated Federal repository. Cash on hand will be deposited daily or on the next business day, whenever possible, to reduce funds held at risk to the holding authority board.

11–19. Internal controls

The MSA must have in place a system of internal controls to ensure that assets and funds of the Government are not lost. The MSA must have the internal controls codified in writing and they must be reviewed and updated annually as required. As a minimum the controls must provide—

- a. Physical security of U.S. assets. Included in the definition of assets are—
 - (1) Checks,
 - (2) Negotiable instruments,
 - (3) Documents representing assets (accounts receivable),
 - (4) Cash,
 - (5) Equipment,
 - (6) Stamps,
 - (7) Bonds, and
 - (8) Vouchers.
- b. Separation of duties to preclude one individual from having complete control over a financial transaction. For example, no single person should be able to bill, collect, disburse, and account for a transaction.
- c. Physical separation of persons handling cash or engaged in complementary activities. An example of a complementary activity is billing and collecting.
- d. Task assignment so that employees charged with receiving mail do not participate in the accounting, billing, collection, or accounting process. Checks or cash received in the mail must be logged in by the receiving employees and transferred by transmittal letter to the MSA.
- e. A mechanism to track custody of public funds, assets, and vouchers.
- f. Proper protection of safe keys and combinations.
- g. Exclusive control by employees with custody of public funds over those funds. Oral instructions concerning funds of the Government, vouchers, records, etc., will not supersede published regulations. Instructions that do not appear in regulations must be in writing.
- h. Briefings to employees on their responsibilities concerning internal controls and liability for losses. The briefings must cover as a minimum the concepts of presumption of negligence, loss burden of proof, and personal liability for loss.
- i. A written standing operating procedure (SOP) for each position that has responsibility for Government assets. It is the supervisor’s responsibility to ensure that there are written SOPs.
- j. Procedures in place to guarantee computer security.
- k. A lock box located outside the cashier cage for duplicate copies of collection and disbursing vouchers. (This is applicable only to those MSA activities that operate a cashier operation.)
- l. Transfers of documents and funds to the supporting DAO on sequentially numbered transmittal letters.
- m. PTFs the same level of security as Government funds.
- n. Adequate physical security to protect the assets entrusted to the MSA. Physical security is provided by safes, locked cash drawers, lockable fire proof files, secure limited access doors, cages, alarm systems, and other devices.
- o. A mechanism to account for and inventory bills and other evidence of debt which are held in hard copy format and not reflected in the primary financial reports. These evidences of debt should be periodically reconciled to the controlling records and reported in the related financial statements.

(Letterhead)

OFFICE SYMBOL (MARKS Number)

MEMORANDUM THRU (Chief, PAD)

FOR (MTF Commander)

SUBJECT: MSA Transfer Certificate

I certify that, to the best of my knowledge and belief, the attached is an accurate and complete summary of all outstanding accounts receivable and an accurate listing of controlled forms on hand as of (time) (date).

All transactions within the MSA as of (time) (date) are accurately shown on the accounts and records of the MSA and are documented by copies of DD Form 1131, DA Form 3929, DA Form 3155, and other authorized documents. All MSA records and accounts are transferred to my successor.

Signature of MSAO

Date

Typed name and grade

I certify that I have examined and verified the MSA accounts and records covered by the above certification, verified the change fund, and accept the accountability as of (time)(date).

Signature of relieving officer

Typed name and grade

Signature of facility commander

Typed name and grade

Figure 11-1. Sample memorandum format for MSA transfer certificate

(Letterhead)

OFFICE SYMBOL (MARKS Number)

MEMORANDUM THRU (Chief, PAD)

FOR (Local Finance and Accounting Officer)

SUBJECT: MSAO Discontinuance Statement

All transactions through (date), have been posted in the MSA accounts and records of (facility). The change fund (amount) has been returned to the finance and accounting officer and all collections deposited. Controlled forms in my accountability have been transferred to the forms officer and a receipt obtained. Current accounts receivable, DA Form 3154 (Nos. 3 and 4 copies) or authorized facsimiles machine generated, totaling (\$sum), and other MSA records are transferred to—

(Name and grade of finance and accounting officer)

(Name and address of installation or activity)

(Date)

(Signature of MSAO)

(Typed name and grade)

I have examined the MSA accounts and records covered by the above statement and accept the accountability and records.

(Date)

(Signature of servicing FAO)

(Typed name and grade)

APPROVED:

(Date)

(Signature of facility commander)

(Typed name and grade)

Figure 11-2. Sample memorandum format for MSAO discontinuance statement

(Letterhead)

OFFICE SYMBOL (MARKS Number)

MEMORANDUM FOR (Chief, PAD)

SUBJECT: Statement of Outgoing Custodian

I have, this 26th day of June 1998, transferred to LTC John Smith, the new custodian, \$250.00 cash on hand and \$40.00 on deposit to the credit of the patients' trust fund in Eisenhower Bank and all items listed on patients' deposit records

(MSAO Signature)
(Grade and SSN)

Figure 11-3. Sample memorandum format for statement of outgoing custodian

(Letterhead)

OFFICE SYMBOL (MARKS Number)

MEMORANDUM FOR (Chief, PAD)

SUBJECT: Statement of New Custodian

I have, this 26th day of June 1998, received from LTC Thomas Wise, the sum of \$560.00 representing the balance due patients, together with the valuables listed on the individual patients' deposit records, and I hereby relieve him/her from all responsibility for the patients' trust fund.

(New MSAO Signature)
(Grade and SSN)

Figure 11-4. Sample memorandum format for statement of new custodian

Chapter 12

Patients' Trust Fund

12-1. Purpose

This chapter prescribes the accountability and control of patients' personal funds and valuables in Army MTFs. The Medical Services Account Users' Manual prescribes procedures for PTF transactions.

12-2. Administration

No council is necessary for the administration of a PTF.

12-3. Responsibilities

a. The MTF commander will be responsible for the overall operation of the PTF and for the proper safeguarding of patients' funds and valuables. Specifically he or she will—

- (1) Designate in writing an officer, warrant officer, or civilian employee as custodian of the PTF during both duty and after-duty hours.
- (2) Designate in writing such additional individuals as are required for the efficient operation of the PTF during both duty and after duty hours.
- (3) Determine the amount of cash to be kept on hand in the change fund and notify the custodian in writing of the amount authorized.
- (4) Ensure the implementation and maintenance of a viable internal control program.

b. The custodian of the PTF will be responsible for the receipt, safekeeping, disbursements, and accounting for patients' funds and valuables deposited with the fund. If the custodian is absent in excess of 30 days, the MTF commander will appoint a replacement to assume the duties of the custodian.

12-4. Transfer of funds and valuables to successor custodians

When a custodian is relieved and a successor custodian designated, transfer or accountability of the PTF will be accomplished as described in a through e below.

a. The retiring custodian will close and balance the DA Form 4128 (Patients' Trust Fund Journal) as of the date of transfer to include a cash (on hand) count and a trial balance of the funds on deposit per DA Form 3696 (Patient's Deposit Record). In addition, a reconciliation will be prepared to show both the bank and journal balances. DA Form 4128 may be obtained through normal distribution channels. DA Form 3696 is available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web (<http://www.usapa.army.mil/>). The following instructions are furnished for use in maintaining DA Form 4128:

- (1) Column (a). Enter the date of entry.
- (2) Column (b). Enter the total amount of receipts for the day.
- (3) Column (c). Enter the total amount of cash disbursements for the day.
- (4) Column (d). Enter the total amount of check disbursements for the day.
- (5) Column (e). Enter the sum of columns (c) and (d).
- (6) Column (f). To the previous day's balance, add the receipts shown in column (b), deduct therefrom the withdrawals shown in column (e), and enter the total. At the beginning of each month, the initial entry will be the fund balance brought forward from the last day of the preceding month.
- (7) Column (g). To the previous day's balance, add the receipts shown in column (b), deduct the cash withdrawals shown in column (c), and enter the total except when it exceeds the authorized amount of the change fund. In this case, enter the authorized amount of the change fund, and record the difference between total cash on hand and the authorized amount of change fund "for deposit" in column (h). At the beginning of each month, the initial entry will be the change fund balance brought forward from the last day of the preceding month.
- (8) Column (h). Enter the amount for deposit as computed in column (g). The amount may be accumulated until a deposit is made.
- (9) Column (i). Enter the number of the check drawn to bring the change fund up to the authorized amount.
- (10) Column (j). When the change fund falls below the authorized amount, a check will be drawn to bring the change fund up to the authorized amount. The amount of the check will be entered in this column.
- (11) Column (k). Enter the sum of columns (g) and (h) or (j), as applicable.
- (12) Column (l). Enter the bank balance per checkbook. At the beginning of each month, the initial entry will be the bank balance brought forward from the last day of the preceding month.
- (13) Column (m). Enter the sum of columns (k) and (l). This figure should balance with the figures shown in

column (f). At the beginning of each month, the initial entry will be the total fund balance brought forward from the last day of the preceding month.

(14) Column (n). Enter any pertinent remarks to this column.

b. The joint statement in figure 11-3 will be prepared in quadruplicate and all copies signed by the retiring custodian.

c. Records, keys, cash, valuables, etc., will be turned over to the succeeding custodian who will sign all copies of the above statement after satisfaction that no discrepancy exists.

d. When actual transfer of the PTF has been accomplished, the original of the above statement, accompanied by a signature card bearing the signature of the new custodian, will be forwarded to the hospital commander. The MTF commander will give written notice of the change to the local bank and will enclose the signature card of the new custodian. The three remaining copies of the above custodian's statement will be distributed to the outgoing custodian, the new custodian, and the files of the PTF.

e. Where a safe has been provided for use by the custodian, the combination will be changed as prescribed in AR 37-103. Use of the MSA safe should be avoided when possible. PTF activities should be separated from ongoing MSA collections, disbursing, and billing operations.

12-5. Operating principles

a. Items other than funds and valuables will not be accepted for deposit in the PTF.

b. Firearms or other weapons or objects which could be considered a menace to safety or health, other than Government property, will be receipted for and turned over to the MHU commander or other responsible activity for safekeeping and disposition.

c. The PTF will not be used for the safeguarding of funds and valuables belonging to individuals not in a patient status.

d. No investments or loans may be made with the funds on deposit.

e. No donations or contributions may be made or received by the PTF.

f. Money deposited in the PTF will not be used for purposes of cashing checks. Checks will not be accepted for deposit as cash.

g. Disbursements will be made by check whenever practicable. Disbursements will be made only to a patient who is a depositor (whether or not he or she is physically able to sign the necessary forms) except as follows:

(1) A disbursement may be made to an intermediate individual upon written authorization of the patient depositor.

(2) A check may be drawn payable to the individual assuming custody of a mentally incompetent patient upon discharge.

(3) A check may be drawn payable to the custodian of a PTF for a cash on hand reimbursement.

(4) A check may be drawn payable to the Treasurer of the United States for the transfer of unclaimed monies or overages.

h. In MTFs where various elements are located separately or at considerable distance from one another, the commander may authorize the operation of a separate subfund. This subfund will operate as prescribed in this chapter, with the custodian of the PTF retaining responsibility for its operation. The custodian will authorize the transfer of the applicable deposit records and establish a change fund. Daily or weekly, as appropriate, a summary of all receipts and disbursements and cash on hand will be prepared in duplicate, and the original submitted together with a deposit or request for reimbursement of change fund, as applicable, to the (main) PTF. Totals from the summary of the subfund transactions will be posted separately to the DA Form 4128.

i. The custody and accountability for the funds and property of hospitalized prisoners is the responsibility of the commander of the installation confinement facility according to AR 210-174. The custodian of the PTF will not be designated the custodian of the prisoners' personal deposit fund; however, the PTF may be used for the safekeeping of those belongings of hospitalized prisoners which prisoners are permitted to retain. Other items must be placed in the prisoners's personal deposit fund.

12-6. Safeguarding of funds and valuables

The custodian will maintain positive internal control processes over all funds and valuables to ensure accountability to a designated individual at all times.

a. *Deposits.* All funds deposited in a Federal depository will be placed in a suspense account. Under exceptional circumstances, an account may be established in a commercial bank. This exception is generally applicable for activities operating OCONUS. Permission to establish such an account must be obtained from DFAS-Indianapolis Center, 8899 East 56th Street, Indianapolis, IN 46249.

(1) When a patient arrives with cash in any amount, the PTF custodian will offer to secure the cash in excess of \$20.00 and other valuables for the patient. Cash will be deposited with the supporting DAO, Federal depository, or held at risk in the hospital safe. At the time of the deposit to the DAO or Federal depository, the PTF custodian will request that a check equal to the cash deposited be drafted on the Treasury of the U.S. payable to the patient. Copies of the collection, deposit, and disbursing document will be kept separately by the MSA, custodian, and a copy provided to

the patient. The check will be logged in and maintained by the PTF custodian. A nominal amount of cash may be kept by the patient or in trust by the custodian at the patient's request.

(2) Deposits and requests for checks will be made through the MSA. A separate deposit slip and collection voucher will be used for each patient.

(3) The chief of PAD will ensure the security of the PTF by periodically reviewing internal controls and SOPs. On a random monthly basis, the chief of PAD will assign a disinterested third party to audit the PTF.

b. Valuables. Valuables will be placed in a safe or other container or room which provides the same degree of protection.

c. Loss of funds or valuables. When a shortage in the funds or a loss of property is discovered, the matter will be investigated and disposed of according to AR 15-6. When losses of funds are not recoverable and it has been determined that there was no fraud, dishonesty, or willful misconduct and no one is held pecuniarily liable, the fund should be liquidated and a claim initiated against the Government according to AR 27-20.

12-7. Forms

DA Form 3696, DA Form 3983 (Patients' Trust Fund—Authorization for Deposit or Withdrawal of Funds and Valuables), DA Form 4128, and DA Form 4665 (Patients' Trust Fund—Daily Summary Record) will be used to record deposit and withdrawal of funds and valuables and central PTF accountability. DA Form 3983 and DA Form 4665 are available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web site (www.usapa.army.mil)

12-8. Procedures upon admission

When admitted to the hospital, the patient will be informed that the hospital assumes no liability or responsibility for the loss of funds or valuables not placed in deposit. If the patient desires not to make a deposit, DA Form 3696 will be prepared and the statement block indicating that no deposit is desired will be signed by the patient or witnessed, if the patient is unable to sign, the form will be forwarded to the custodian. This procedure need not be utilized by those facilities that have established other means of recording the patients' desire to not use the PTF.

12-9. Audit

The PTF will be audited annually and at any other time deemed appropriate by the MTF commander.

Chapter 13

Injury and Illness Cases-Medical Affirmative Claims

13-1. General

a. Purpose.

(1) The Federal Medical Care Recovery Act, 42 USC 2651-2653, established the U.S. Government's independent right to recover the reasonable value of health care services provided at Government expense to an individual as a result of an injury or illness incurred under circumstances creating a tort liability upon some third person.

(2) 10 USC 1095 provides authority for military health care facilities to collect the reasonable costs of health care from health insurance and Medicare supplemental policies. 10 USC 1095 also authorizes the U.S. to recover from automobile liability, medical payments, and personal injury protection or no-fault insurance. This chapter establishes procedures in support of medical affirmative claims.

b. Applicability. The provisions of this chapter do not apply to battle casualties or to claims between Federal agencies.

c. Recovery judge advocate (RJA). The term "RJA" as used in this chapter means the legal advisor in the Office of the SJA assigned responsibility for asserting a medical affirmative claim. The RJA normally will work in the designated judge advocate office that furnishes legal services to the Army hospital that provided the initial treatment or hospitalization of an injured person entitled to medical care at Army expense. This is generally the judge advocate or legal advisor of the command or installation supporting the Army MTF. Geographic areas assigned to an RJA generally coincide with the geographic areas assigned to MEDDAC/MEDCEN commanders. The designated RJA is responsible for asserting, pursuing, and settling claims arising from an injury or illness as a result of a recoverable accident or incident. In cases where more than one treatment facility provides medical care to a beneficiary, the responsibility for recovery may be transferred to another claims office, depending on which office has the most significant interest in a particular claim (AR 27-20 and DA Pam 27-162).

d. Medical affirmative claim. A medical affirmative claim is a claim-other than a health insurance claim-asserted in favor of the U.S., for the reasonable value of health care services furnished at Government expense. These claims include, but are not limited to, claims asserted against automobile and motorcycle insurance, including personal injury protection and medical payment coverage, or uninsured/underinsured provisions; homeowner's or renter's policies; products, premises, or general liability policies; and worker's compensation (on-the-job injury) funds. These claims

were previously referred to as third party liability (TPL) claims and are commonly referred to as Federal Medical Care Recovery Act claims.

e. Health care services. The term “health care services” includes all medical care furnished by or at the expense of the U.S. Government. This includes care or services furnished in or through an MTF, including emergency care provided to AD soldiers in civilian hospitals at Government expense, services paid with supplemental funds, or care or services provided through the TRICARE Program. Health care services include, but are not limited to, inpatient or outpatient treatment, dental care, nursing services, high cost ancillary services or pharmaceuticals ordered by a civilian provider but provided by a military facility, ambulance services, durable medical equipment, prostheses or medical appliances, and home health care.

f. Claim form. A completed DA Form 2631 (Medical Care-Third Party Liability Notification) (or automated equivalent) may be used as a claim form for medical affirmative claims. DA Form 2631 is available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web (<http://www.usapa.army.mil/>). MTFs may, with the agreement of the responsible RJA, use a completed UB-92 claim form in lieu of the DA Form 2631. The UB-92 claim form is a universal health care claim form and is used for Third Party Collection Program (TPCP) health insurance claims. Applicable ICD-9-CM and current procedural terminology (4th edition) (CPT4) codes will be entered on all claim forms.

13–2. Interface and support

MTFs are the primary source of information regarding potential or ongoing medical affirmative claims. Pursuant to a Memorandum of Agreement between TSG and The Judge Advocate General, MTFs must consider using a portion of the funds collected by the Office of the Staff Judge Advocate (OSJA) claims offices to offset some of the OSJAs costs of operating the medical affirmative claims program.

a. MTFs will ensure patients are queried regarding how, when, and where all injury or illness occurred. MTFs will utilize existing TPCP procedures to the greatest extent possible to ensure pertinent accident and insurance information is obtained at point of entry or point of treatment. These procedures include, but are not limited to, pre-admission and admission interviews, and documentation of insurance declaration forms or TPCP clinic encounter forms. DD Form 2569 (Third Party Collection Program-Insurance Information) will be completed on injury patients.

b. MTFs and RJAs will implement procedures to ensure that the following are screened for potential recovery action: outpatient medical records and other outpatient documentation (for example, emergency room logs, physical therapy records, outpatient clinic encounter forms and records), inpatient records, requests for high cost ancillary services, pharmaceuticals ordered by outside providers, and supplemental care.

c. Overdose injuries and self-inflicted injuries are not appropriate for initiation of an affirmative claim against an individual entitled to care in an MTF, but may be appropriate to assert a claim against an individual’s health insurance.

d. In addition to automobile accidents, the following may be appropriate for initiation of an affirmative claim:

- (1) Traffic, airplane, or boating accidents.
- (2) Slip and falls.
- (3) On-premise accidents.
- (4) Job related or on-the-job accidents.
- (5) Product or equipment malfunctions or failures.
- (6) Medical malpractice by a civilian provider.

e. Authority to collect for medical affirmative claims extends to AD soldiers. Therefore, AD soldiers must also be queried and their medical records reviewed for potential recovery action.

f. MTFs will establish internal controls for the timely reporting of information regarding medical affirmative claims to the RJAs.

g. The responsible RJA will provide to the MTFs—

- (1) A copy of medical affirmative claims deposit vouchers for collections deposited to an MTFs account; or
- (2) A monthly report containing relevant patient information including the patient’s name, sponsor’s name and SSN, dates of treatment, name of the insurer, and the amount(s) deposited to the MTFs account by the RJA for MTF referred affirmative claims; the date of deposit and voucher number; and
- (3) A list of the referring MTFs claims closed without recovery and claims transferred to another claims jurisdiction during the report month. This list must contain pertinent claimant and claim information.

h. Different RJAs may deposit collections to an MTFs designated medical affirmative claim account (source code “937” account). The local RJA is not responsible for the tracking of claims or the deposit of money as a result of claims asserted and/or collected by other RJA offices.

i. When care is rendered in more than one MTF to one or more soldiers/persons involved in the same accident, and the RJA recovers less than the full amount of the Government’s claim, each MTF will receive a pro-rated amount.

13-3. Notification procedures

a. General. MTFs will establish and implement procedures to ensure RJAs receive timely notification of health care services provided to beneficiaries as a result of an accident or illness that may result in a medical affirmative claim.

b. Inpatient care. A copy of the original admission record (DA Form 2985) or its equivalent will be used to notify the RJA of all patients with injuries or illnesses admitted either as a direct admission to an MTF, or those patients for whom administrative responsibility has been assumed regardless of the circumstances under which the injury or illness was incurred.

(1) The section titled "For Local Use" will be used to record the accident information of how, when, and where the injury occurred.

(2) The DA Form 2985 will be forwarded to the RJA within 3 working days after the day of admission for screening and determination of a potential medical affirmative claim. The RJA will return the form to the MTF promptly with one of the following notations: "No Medical Affirmative Claim" or "Possible Medical Affirmative Claim." A claim form (DA Form 2631) will be requested, when required, by the RJA.

(3) If it has been determined that a possible medical affirmative claim exists, the notation: "Medical Affirmative Claim-Public Law 87-693 and 10 USC 1095" will be entered in item 29 of DA Form 3647 (Inpatient Treatment Record Cover Sheet) (or automated equivalent) upon its completion. If the DA Form 3647 has been completed prior to the determination that a possible medical affirmative claim exists, a corrected form will be prepared. DA Form 3647-1 (Inpatient Treatment Record Cover Sheet (for Plate Imprinting)) can be used to transfer diagnoses and procedures to the CHCS worksheet. Instructions for the use of these forms can be found in the IPDS Users' Manual. DA Form 3647 (4-part set) is available on the Army Electronic Library D-ROM (EM 0001) and on the USAPA web (WWW.usapa.army.mil). DA Form 3647 (4-part continuous set) will be distributed through normal channels. DA Form 3647-1 is available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web (WWW.usapa.army.mil).

(4) The notated admission record (DA Form 2985) will become a permanent part of the clinical record.

c. Outpatient care. MTFs and RJAs will establish local procedures to ensure the RJA is appropriately notified regarding potentially recoverable outpatient treatment. See paragraph 13-2 regarding identification of recoverable outpatient treatment. Claim forms and copies of pertinent medical documentation will be provided to the RJA.

13-4. Absent sick active duty personnel

a. The RJA notification procedure described in paragraph 13-3 will be followed for absent sick AD soldiers treated for an injury or illness incurred due to a potentially recoverable incident.

b. Unless the determination has been made by the RJA that no medical affirmative claim exists, the responsible MTF will obtain and provide the RJA with copies of documents supporting the cost and provision of health care services to absent sick AD soldiers. This includes, but is not limited to, copies of bills or appropriate vouchers supporting the payments and medical records or other medical documentation.

13-5. Medical records

a. Requests for medical records/information pertinent to patients treated for a potentially recoverable incident are subject to the following:

(1) MTFs must route all requests pertaining to potentially recoverable incidents and/or replies to such requests for medical records or medical information from all sources, other than those related to TPCP pre-certification and utilization review, through the RJA for release. These include but are not limited to requests from patients, attorneys, and insurance companies.

(2) Excuse from work requests are often received for patients treated for an injury or illness incurred as a result of an on-the-job or other recoverable incident. These requests must be reviewed carefully to ensure potentially recoverable treatment is identified and the RJA is appropriately notified. The RJA is responsible for determining whether a patient's treatment represents a recoverable claim.

b. A copy of DA Form 3647 (or automated equivalent) and SF 502, if available, will accompany the claim form submitted to the RJA. If the narrative summary is not available when the claim form is forwarded to the RJA, it will be forwarded immediately upon completion.

c. Copies of pertinent inpatient medical records or other documentation will be provided to the RJA upon request.

d. MTFs will provide copies of applicable outpatient records, ambulatory surgery records, or other supporting documentation, such as clinic encounter forms, physical therapy records, etc., to the RJA with the completed claim form.

13-6. Medical claim forms

a. Transfer patient. For all cases except those for which the RJA has determined that no medical affirmative claim exists, the MTF will prepare and forward to the RJA a transfer claim form (DA Form 2631) within 3 working days after the day of transfer or movement of the patient.

b. Filing of form. A copy of each claim form (DA Form 2631 or its substitute (para 13-1f)), submitted to the RJA, will become a permanent part of the clinical record.

c. *DA Form 2631*. (See para 13-1f for an explanation of substituting the UB-92 for this form.) Completion of the form is self-explanatory except for the following items:

(1) Military source care.

(a) In item 6, Disposition or Status of Patient, if the patient has been released from the MTF, enter the date and type of disposition. If transferred or moved from the MTF, enter the MTF to which dispositioned. If currently on the rolls of the MTF, enter status (that is, occupying a bed, on leave, AWOL, subsisting elsewhere, or TDY).

(b) In item 11a, Total Days, enter the number of days from admission to disposition or date of report.

(c) In item 11b, Days Absent from Hospital, enter the number of the days that were included in 11a during which the patient was absent from the hospital (such as pass days, etc.).

(d) In item 11c, Net Days, enter the number of days the patient was actually in the hospital (11a minus 11b).

(e) In 11d, Rate, enter the appropriate inpatient rate as stated in the applicable Federal Register.

(f) In 11e, Total, if a per diem rate is applicable, enter the total charge for active hospitalization (11c multiplied by 11d). If a DRG rate is applicable, enter the full DRG charge. The DRG code and corresponding full written description of the DRG code will be entered in Item 8, Diagnosis, section of the form.

(g) In 11f, Paid, enter any amount paid locally by the patient or on behalf of the patient by anyone other than an agency of the Federal Government. Record the payer's name. Enter only amounts received by the MSA as of the day the notification is submitted. Promises to pay, arrangements for partial payments, or other transactions, such as transfer of the account to the FAO, will not be reflected. If any amounts are received after the notification is submitted, a corrected claim form (DA Form 2631) will be submitted.

(h) In 11g, Balance, enter the unpaid charges (11e minus 11f).

(i) In 12a, Visits, enter the number of outpatient visits by clinical service and/or other applicable outpatient charges, such as high cost ancillary services or pharmaceuticals ordered by a civilian provider but provided by the MTF (for example, MRI).

(j) In 12b, Rate, enter the applicable clinical service outpatient visit rate or other appropriate charge stated in the applicable Federal Register or regulation.

(k) In 12c, Total, enter the total charge for all outpatient care (12a multiplied by 12b). If there are multiple outpatient services and/or multiple sources of care, an itemized list of the charges may be provided on an attached sheet of white bond paper. The list must contain the patient's name and SSN, each provider/practitioner's full name and address, the treatment date(s), the applicable ICD-9-CM and CPT4 codes, and the applicable provider/practitioner charge for each date(s) of treatment. The notation "See attached list" will be entered in Block 12, and the cumulative total of all charges noted on the list will be entered in block 12c of the DA Form 2631.

(l) In 12d, Paid, enter any amount paid locally by the patient, or on behalf of the patient, by anyone other than an agency of the Federal Government. Record the payer's name. Enter only amounts received by the MSA as of the day the notification is submitted. Promises to pay, arrangements for partial payments, or other transactions, such as transfer of the account to the FAO, will not be reflected. If any amounts are received after the notification is submitted, a corrected claim form (DA Form 2631) will be submitted.

(m) In 12e, Balance, enter the unpaid charges (12c minus 12d).

(2) Civilian source care.

(a) Item 13 includes any health care service obtained from a nonmilitary source. These include, but are not limited to, emergent/urgent outpatient care provided to AD soldiers and care obtained from civilian sources but paid for by an MTF (such as care paid through the Supplemental Care Program).

(b) In 13a, enter type of care (outpatient, inpatient, ambulance, etc.).

(c) In 13b, enter name and address of provider/practitioner or source of care.

(d) In 13c, enter date(s) of care.

(e) In 13d, enter associated charge(s). If there are multiple civilian sources of care, an itemized list of charges may be provided on an attached sheet of plain white bond paper. The itemized list must contain the patient's name, rank, and SSN, each provider/practitioner's full name and address, the treatment date(s), and the applicable provider/practitioner charge for each date(s) of treatment. The notation "See attached list" will be entered in block 13b and the cumulative total of all charges noted on the list will be entered in block 13d of the DA Form 2631.

d. *Consolidated statement of charges*.

(1) When so requested by the RJA, the Army MTF will prepare a consolidated statement of charges. DA Form 3154 (or automated equivalent) will be used for this purpose. The information regarding all charges (military and civilian) pertaining to the injury giving rise to the claim or expected litigation will be summarized. Totals will be entered in the appropriate section of the DA Form 3154. When information is available that payment has been made by the Army to civilian source(s), the amount paid by the Army will be entered in "Remarks" as follows: "Payment for care received from civilian sources-see attached voucher(s)." The original and one copy of the DA Form 3154, used as required by this paragraph, and with copies of supporting documentation, will be forwarded to the requesting RJA. The remaining copies (3 and 4) will be conspicuously marked "USED FOR MEDICAL AFFIRMATIVE CLAIM BILLING ONLY" and filed in the "Invoice Issued" file without being processed through the MSA.

(2) When it is apparent from the patient's record that care was obtained at Army expense and information on the value or cost of such care is not contained in the record, the MTF will obtain the necessary data regarding such care for inclusion in the consolidated statement. MTFs will provide copies of the supporting documentation to the RJA upon receipt.

13-7. Concurrent medical affirmative claims and Third Party Collection Program health insurance claims

a. A beneficiary may be covered by both health benefits insurance and another type of insurance, such as automobile. Consequently, there would be more than one insurer. However, the Government cannot collect more than the cost of medical care from any one source or combination of sources.

b. MTFs and RJAs will establish procedures to facilitate the exchange of information regarding claims and ensure coordination between the MTF and the RJA regarding any concurrent TPCP health insurance claim(s) and subsequent payment(s).

(1) When a beneficiary is covered by both a TPCP health benefits insurance claim and a medical affirmative claim, the MTF will simultaneously—

(a) File the MTFs TPCP health benefits insurance claim;

(b) Notify the RJA of the MTFs concurrent TPCP health insurance claim; and

(c) Provide the RJA with information regarding the potential or ongoing medical affirmative claim.

(2) Initial notification to the RJA regarding a potential medical affirmative claim cannot be postponed until payment has been received from the TPCP insurer. The RJA must be notified promptly of treatment for an illness or injury due to a potentially recoverable incident in order for the RJA to proceed with the investigation of the incident and meet assertion and notification deadlines.

(3) When the beneficiary is covered by worker's compensation (non-Federal employer) for a job-related injury or illness, the MTF does not file a claim with the patient's health benefits insurer. On-the-job injury claims are filed by the RJA as a medical affirmative claim. They are not a TPCP health insurance claim. (See appropriate regulations regarding on-the-job injury claims for Federal employees.)

(4) MTFs will, upon receipt, provide pertinent information regarding health insurance payment(s) or denials on concurrent medical affirmative claims to the RJA. This information will include relevant patient and spousal information, dates of treatment, name of health insurer, the amount claimed, and the amount of payment(s); or, the denial date and reason for denial. A copy of the TPCP claim form(s), the insurance explanation of benefits form(s), or denial will be provided to the RJA on request. The RJA will adjust the asserted amount of the medical affirmative claim accordingly. A copy of the transmittals to the RJA regarding concurrent TPCP health insurance claims will be maintained with the TPCP claim as part of the file.

13-8. Civilian care furnished family members and retirees in the United States, Puerto Rico, Canada, and Mexico

The Director, TRICARE Support Office, has responsibility for issuing directives regarding procedures to be followed by civilian MTFs and fiscal intermediaries when family members or retirees receive initial care and treatment, necessitated by a traumatic injury, at civilian facilities as TRICARE beneficiaries. These directives require that—

a. Notification is made to the RJA or other legal official according to AR 27-20.

b. Invoices, statements of account, statement of causative factors, and other available information specifically requested by the individual mentioned in *a* above, are furnished.

c. The DD Form 2527 (Statement of Personal Injury- Possible Third Party Liability-CHAMPUS) is completed, according to instructions on the form, by the injured party, sponsor, or other responsible family member as soon as possible after the patient's treatment by a civilian provider/practitioner.

d. A copy of the completed DD Form 2527 is furnished to the appropriate RJA as soon as possible so that he or she may advise the injured party according to AR 27-20.

13-9. Civilian care furnished family members and retirees in the European command

When payment is made for civilian inpatient care and it appears that the care was necessitated by a traumatic injury, the Executive Director, TRICARE Support Office, Europe, will furnish the information required in paragraph 13-8 to the appropriate Service commander.

13-10. Civilian care furnished family members and retirees in areas other than the United States, Puerto Rico, Canada, Mexico, and in the European command

Approving authorities (DOD 6010.8-R), who process payments to sources of civilian health services or claims for reimbursement for civilian inpatient care obtained by TRICARE beneficiaries, will forward a copy of the approved SF 1034 and 1034A, and, if appropriate, a copy of DA Form 1863-1 (Services and/or Supplies Provided by Civilian Hospitals) to the RJA in all injury cases where the patient was hospitalized or obtained emergent or urgent care.

13-11. Claims for reimbursement for civilian care

Instructions relevant to claims for reimbursement for civilian care can be found at the TRICARE/DOD Health Affairs web site (<http://www.tricare.osd.mil/>).

13-12. Care in medical treatment facilities of a foreign government

The notification procedures required in paragraphs 13-8 through 13-11, as applicable, will be followed when payments are made to a foreign government for trauma-related care provided to individuals whose medical treatment is the responsibility of the U.S. Army.

Chapter 14

Third Party Collection Program

14-1. Policy

a. The cost of medical services provided to DOD beneficiaries will be collected from third party payers to the fullest extent allowed under 10 USC 1095 and according to DODI 6015.23.

b. Each MTF commander must designate an office responsible for TPCP implementation to include program awareness, identifying and collecting insurance information, billing third party payers, collecting and depositing funds, training, and reporting TPCP status.

c. Effective TPCP implementation necessitates the participation of many elements within the MTF including physician and nursing staffs, admissions, medical records, utilization review, ancillary departments, management information, legal, and fiscal offices.

d. The TPCP will, as a minimum, identify those Uniformed Services beneficiaries with third party payer plan coverage, submit all claims to third party payers, ensure that collections are made, and document and report collection activities.

e. The MTF commander will ensure compliance outlined for third party payers under 32 CFR 220 and DOD 6010.15-M.

f. For inpatient hospital care, authority to collect applies to an insurance, medical service, or health plan agreement entered into, amended, or renewed on or after April 7, 1986. For Medicare supplemental plans, automobile liability (including uninsured/underinsured) and no-fault (for example, personal injury protection) insurance plans, outpatient care and ambulatory surgical care, authority to collect also applies to an insurance, medical service, or health plan agreement entered into, amended, or renewed on or after November 5, 1990. An amendment may include, but is not limited to, premium rate changes, benefit changes, carrier changes, or conversions from insured plans to self-insured plans or the reverse.

14-2. Health care plans not subject to the Third Party Collection Program

a. The TPCP will not file claims to Medicare, Medicaid, or TRICARE Programs. Additionally, it will not file claims with supplemental insurance plans designed to cover the patient's cost share of the TRICARE Program or to income (or wage) supplemental plans.

b. The MTF will file claims to Medicare supplemental plans according to the current applicable CFR.

14-3. Medical services billed

MTFs are authorized to file health benefits claims only for the health care services authorized in the current CFR or more recent Federal register.

14-4. Medical services not billed

Claims will not be filed for health care services for which rates have not yet been established by OASD(HA). MTFs are not authorized to establish rates in the absence of DOD provided rates. Rates are also published annually in the Federal register.

14-5. Identification of beneficiaries who have other health insurance

a. Timely and accurate identification of beneficiaries who have other health insurance is crucial to a successful TPCP.

b. Each MTF commander will ensure that beneficiaries who have other health insurance are informed of legislative requirements and benefits of the TPCP, types of insurance plans subject to collection, and the patient's responsibility, as applicable.

c. Pre-admission, admission, and outpatient staff will—

(1) Ascertain Medicare enrollment status for all patients age 65 and older including Medicare Part A (hospitalization, skilled nursing care, and home health care) and Medicare Part B (ancillary and professional services) enrollment.

(2) Ascertain Medicare enrollment status for all patients under age 65 entitled to Medicare on the basis of disability or end-stage renal disease (that is, kidney failure).

(3) Obtain a completed, signed DD Form 2569 (Third Party Collection Program-Insurance Information) at the time of preadmission, admission, or outpatient visit/encounter. In addition, TPCP pre-certification or other TPCP staff must check the DD Form 2569 and complete any missing fields (for example, patient insurance/employer information) prior to patient discharge or release. The MTF must obtain a yearly, updated, signed DD Form 2569 for every patient.

(4) Establish a process whereby all patients not having other health insurance are queried about their other health insurance status upon discharge. Annually, thereafter, the patient must update and sign a new form on their first visit or admission in each 12 month period.

d. For beneficiaries with coverage, the insurance company name and policy ID information-including employer name, address, and phone number, policy and group number, and member ID-will be obtained. Insurance information obtained during admission, discharge, or visit-including negative responses-should be entered on DD Form 2569. (DOD 6010.15-M contains instructions for the use of this form.)

e. Patient interviews regarding health insurance coverage will be conducted according to instructions in the current DOD 6010.15-M. The patient should be asked if their admission/visit is due to an injury sustained in an accident (when, where, and type (for example, automobile, slip and fall, medical malpractice, work related, defective products, homeowners'/renters', boat and airplane, etc.)). In addition, relevant accident insurance information (policy holder name, ID number and insurer name, address, phone number, etc.) and complete employment information should be obtained. The goal of the interview is to obtain employment, insurance, and accident information.

14-6. Mandatory compliance by health insurance carriers

a. Insurance companies and other health insurance plans must abide by the provisions of Public Law 99-272 (incorporated into 10 USC 1095). Insurance companies cannot deny claims nor reduce payment on claims based on the fact that care was rendered in a Government facility. Claims reduced or denied for these and other invalid reasons will be referred to the appropriate Regional Claims Settlement Legal Office or designated legal office. Payment is not contingent upon the military facility entering into a participation or other agreement with the insurance entity. The current CFR also serves as a guide for the identification and documentation of payment denials for valid reasons.

b. MTFs may reach an understanding with third party payers on claims procedures and other administrative matters if the understanding is not a precondition to complying with State and local statutory and regulatory requirements.

14-7. Authorization to release medical information in support of the Third Party Collection Program

a. MTFs must make available, upon request by third party payers, applicable health care records of the patients for whom payment is sought. This applies only to those records necessary to verify the services provided and that permissible terms and conditions of the plan were met. In these instances, the MTF must not charge payers for copying these records.

b. TPCP personnel must inform patients, at the time insurance information is collected, that medical information relevant to an episode of care being billed must be provided to third party payers if requested. A specific authorization is required for release of alcohol and/or drug abuse, acquired immune deficiency syndrome, and sickle cell medical records. (See AR 40-66.)

14-8. Claims activities

a. Financial accounting for claims, collections, and the disposition of third party claims will be according to DOD 7000.14-R, Volume 4.

b. MTFs that generate third party claims will establish and maintain a claims action log. As a minimum, the data noted on the claims action log will include—

(1) Documentation of all action taken on the claim. This includes but is not limited to the date of each action, names and phone numbers of persons contacted, and a brief summary of conversations.

(2) Amount of claim.

(3) Amount collected.

(4) Reason(s) for invalid payment. An explanation of the reason for the invalid payment or disputed amount stating why the insurance company's payment or denial is not a valid denial.

(5) Disputed unpaid amount.

(6) Final account disposition.

c. TPCP personnel must accurately prepare and submit claims to third party payers. The MTF must use the UB-92 or the HCFA Form 1500.

d. To the extent practical, there should be compliance with the data elements and code specifications of the National Uniform Billing Committee and the Uniform Claim Forms Task Force for submitting claims to third party payers. TPCP personnel must prepare and forward inpatient claims to the third party payer within 10 business days following completion of the medical record and outpatient claims within 7 business days after the outpatient service. The TPCP manager (or representative) should coordinate with the patient administrator or medical records administrator to ensure

that medical records are coded within 30 days following the patient's discharge from the MTF. In situations involving long-term hospitalization of beneficiaries, interim claims should be prepared on a periodic basis, not to exceed 90 day intervals.

e. Claims processing and reporting will be performed according to the current DOD 6010.15-M.

f. If an MTF provides certain high cost ancillary services or prescription drugs based on a request from a source other than a Uniformed Services facility and not incident to an outpatient visit or inpatient service at the MTF, the TPCP office will file TPCP health insurance claims for the specific high cost ancillary rate as authorized by the applicable Federal register.

g. TRICARE contracts specify that the MTF commander and managed care contractor can negotiate a resources sharing arrangement where the contractor hires an individual or individuals to work in the MTF. When a TRICARE contract is implemented, existing partnership agreements expire. When that occurs the MTF must bill the full amount, that is, the appropriate ambulatory, surgical, or outpatient visit rate for patients treated by a resources sharing TRICARE partner provider/practitioner. This includes the professional component of the DOD rate.

h. According to 32 CFR 220, paragraph 220.8(d), for insured family members and retirees, the usual medical services or subsistence charge will not be collected from the patient to the extent that payment received from the payer equals or exceeds the medical service or subsistence charge. The staff must consider these amounts to be included in the amount payable by the plan. If a claim has been resolved and no payment is received or expected from the third party payer, the TPCP office must refer the invoice to the MSAO to bill the patient for the subsistence amount.

i. Claims must be filed with health maintenance organizations (HMOs). HMOs pay for urgent, emergent, and out-of-service area care, and pay according to any point-of-service provisions. MTFs are expected to—

- (1) Identify patients with HMO coverage;
- (2) Certify admissions, file, and pursue all claims with HMOs (inpatient and outpatient);
- (3) Certify all admissions for emergent, urgent, and out-of-service area admissions; and
- (4) Identify all outpatient treatment for emergency, urgent, and out-of-service area care.

j. The TPCP office must prepare separate claims for the mother and baby in an inpatient delivery case.

k. The TPCP office will apply a separate charge for multiple outpatient visits on the same day to different clinics. Multiple visits on the same day to the same clinic must result in only one charge.

l. The MTF has a statutory (or constructive) assignment of benefits and providers/practitioners must pay MTFs directly. The MTF has no responsibility and must not attempt to collect from a patient any amounts erroneously paid to the patient by a third party payer.

m. MTFs will use the Medicare supplemental claims procedures outlined in the current CFRs.

n. 10 USC 1095 collection authority includes automobile liability and no-fault insurance policies. Authority to collect extends to AD soldiers for automobile liability and no-fault insurance policies. (Chap 12 and DOD 6010.15-M contain additional information.) The RJA is responsible for the submission and collection of these claims. Medical affirmative claims are commonly referred to as Federal Medical Care Recovery Act claims and were formerly referred to as Third Party Liability Claims. These claims are pursued by the RJA according to applicable regulations.

14–9. Collection activities

a. Follow-up claims inquiries. If reimbursement is not received within 30 days of the initial filing, either a written or telephonic follow up is conducted. There should be at least one additional follow up 60 days after the initial filing. Follow up must include referral of disputed and/or delinquent TPCP claims to the regional claims settlement office (legal office) not later than 180 days of claims filing. Personnel should follow specific instructions outlined in the DOD 6010.15-M.

b. Deposits. TPCP collection deposits will be according to procedures delineated in the DOD 6010.15-M.

14–10. Minimum internal controls

a. Management/internal controls are described in AR 11-2 and appendix C of this regulation.

b. The MTF commander must ensure that appropriate separation of duties is maintained to minimize the risk of misappropriation of funds. The individual responsible for producing and filing claims must not receive, post, and deposit funds. Separate accounting records should be maintained for both the TPCP and the treasurer offices to provide adequate audit trails.

c. Neither the TPCP manager nor any other person can perform all of the noted duties. There must be a clear delineation of duties for effective internal control. The patient administrator will ensure—

- (1) Appropriate separation of duties involving a minimum of three individuals;
- (2) That separate individuals prepare and mail claims; receive, post, deposit checks, and validate payments; and reconcile TPCP accounting or reporting records; and
- (3) That MSA/TPCP mail is opened in a central area and all checks are immediately placed in an MSA bag for further processing.

d. The MSAO will—

- (1) Receive and open mail including checks or payments.
- (2) Ensure checks are posted (recorded) and deposited within 1 day of receipt. Checks received on a weekend or holiday must be posted and deposited the next working day.
- e. The TPCP officer/manager will—
 - (1) Ensure collections are recorded accurately.
 - (2) Ensure the insurance documents indicating amounts collected equals amounts deposited; ensure that the TPCP records are reconciled with the MSA TPCP deposits; and that the TPCP reports reconcile with the finance and accounting financial records, monthly.
 - (3) Reconcile insurance documents indicating amounts paid with total charges to validate payment of the full amount, less appropriate deductibles and coinsurance.
 - (4) Ensure insurance payments are validated according to current guidance regarding claim closure and procedures for disputed claims.

14–11. Third Party Collection Program reports

a. *Quarterly reports.* Quarterly, each MTF must complete and forward the cumulative TPCP Report on program results to the Commander, USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Fort Sam Houston, TX 78234-6010. DD Form 2571 (Third Party Collection Program-Aging Report) will be provided to the supporting regional claim settlement legal office or Commander, USAMEDCOM, ATTN: MCJA, 2050 Worth Road, Fort Sam Houston, TX 78234-6000 upon request. MTFs must submit quarterly reports on the proper DD Form 2570 (Third Party Collection Program-Report on Program Results) (may be submitted in electronic form), signed by the administrator or responsible official, and explaining any significant variation from prior quarters. Separate DD Forms 2570 must be completed for inpatient and outpatient billing and collection activities. For the purposes of these reports, dollars collected are reported against the year in which the medical service was rendered. The RCS number DD-HA(Q) 1752 and the MTF Defense Medical Information System ID number must be annotated on each MTF quarterly report.

b. *Additional reports.* DOD 6010.15-M provides requirements related to additional reports.

c. *Annual report.* Each MTF must forward a narrative report to the Commander, USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Fort Sam Houston, TX 78234-6010 annually. The report will include the cost of collections and how the collections were spent for the enhancement of health care. A sample format is in DOD 6010.15-M.

14–12. Disposition of claims files

Third party-health plan reimbursable MTF claims are disposed of according to DFAS-IN Regulation 37-1, paragraphs 15-7c, 15-7f(2), and 15-8b. Do not dispose of claims without release from the Regional Claims Settlement Legal Office, coordination or consultation with the Directorate of Resource Management (Accounting and Finance Division), and approval from the Commander, USAMEDCOM, ATTN: MCJA, 2050 Worth Road, Fort Sam Houston, TX 78234-6000.

Chapter 15

Customer Service Division/Patient Administration Systems and Biostatistics Activities

15–1. Authority

AMEDD medical information systems are authorized by this regulation and by the Chief, Customer Service Division (CSD)/Patient Administration Systems and Biostatistics Activity (PASBA), Health Care Systems Support Activity, USAMEDCOM to maintain and prepare functional documentation (functional descriptions, users' manuals, etc.). Data on inpatients in the Military Health System shall be reported to the OASD(HA) according to DODI 6015.23.

15–2. Standard Inpatient Data Record

a. AMEDD personnel process patient records using the current automated and nonautomated systems. Standard data sets and codes are utilized in the Standard Inpatient Data Record (SIDR).

b. CHCS SIDR/IPDS record transmittals will be forwarded electronically to the Commander, U.S. Army Garrison, ATTN: MHD-IMO-CS, 1422 Sultan Drive, Fort Detrick, MD 21702-5020. Files will be created and transmitted according to current procedures developed by the MTF, CHCS systems contractors, and the CSD/PASBA. Records will be submitted twice each month and will be submitted on the scheduled transmittal dates. The end-of-month transmittals will be submitted on the first calendar day of each month; mid-month transmittals will be submitted on the 15th calendar day of each month. Transmittals should not be delayed to await late records which will be forwarded on the next transmittal.

15-3. Data system studies

The MTF will identify and generate information requirements necessary for studies and reporting. Information requirements that exceed the capacity of the local MTF will be referred to the CSD/PASBA.

15-4. Abortion Statistics Report (RCS MED-363)

The DOD has mandated the reporting of all abortions (whether spontaneous or therapeutic (endangered life of mother)) that occur at an Army MTF.

a. MTFs will forward copies of all abortion inpatient treatment record cover sheets (ITRCSs) (except spontaneous/code 634) to the Commander, USAMEDCOM, ATTN: MCHS-ISD, 1216 Stanley Road, Suite 25, Fort Sam Houston, TX 78234-6025. MTFs will implement local SOPs that ensure that these cases are tracked and transmitted. It is recommended that MTFs forward abortion ITRCSs with regularly scheduled transmittals as stated in paragraph 15-2b or as soon as the abortion record is coded. Due to the ongoing special emphasis on diagnostic and procedure coding of abortion records, CSD/PASBA will perform a quality review of ITRCSs for coding accuracy.

b. MTFs will forward ITRCSs with the following abortion codes:

- (1) 630 to 633-Missed abortion, ectopic, and molar pregnancy.
- (2) 635-Legally induced (therapeutic, elective).
- (3) 636-Illegally induced.
- (4) 638-Failed attempted abortion.
- (5) 639-Complications following abortion and ectopic and molar pregnancies.
- (6) Other abortion codes as provided from CSD/PASBA.

15-5. Diagnostic and operative indices

Specific information referencing these two indices can be found in AR 40-66.

15-6. Workload report

Primary Care for the Uniformed Services clinics and other MTFs, as defined in AR 40-4 (except dental facilities) will prepare initial, monthly, and final workload report according to the Worldwide Workload Reporting (WWR) Users' Manual.

15-7. Enabling Care/Patient Tracking System

a. The Enabling Care/Patient Tracking System (EC/PTS) identifies and tracks soldiers with selected injuries and illnesses incurred in the LD. Medical care is tracked through final disposition from the military and through non-military facility care. Categories of injuries and illnesses tracked include burns, amputations, SCIs, traumatic head injuries, traumatic eye injuries, and post traumatic stress disorders. The EC/PTS data base resides on-line at CSD/PASBA. It is available for use by TSG, all MTF DCCSs, MTF Chiefs of PAD, and others with a need to know.

b. Hospital DCCSs and patient administrators are responsible for reporting patient demographic information, diagnosis, prognosis, possible follow-up actions, and the attending physician's name and telephone number to the USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Fort Sam Houston, TX 78234-6010 and to Commander, USAMEDCOM, ATTN: MCHI-ISD, 1216 Stanley Road, Suite 25, Fort Sam Houston, TX 78234-6025. The attending physician is contacted by the appropriate clinical specialist/consultant representing TSG.

c. Patient data is updated as changes occur on-line via the Patient Accounting and Reporting Realtime Tracking System (PARRTS). Reporting requirements are provided by the USAMEDCOM, PAD (MCHO-CL-P).

15-8. Patient administration contingency operations

Patient administrators will establish training programs for administrative personnel assigned to the TOE units. Training should encompass but not be limited to rotations in fixed clinic/MEDDAC/MEDCEN PAD sections including the AAD office, inpatient records, and patient affairs. The goal is to improve soldier skills that will be used in support of deployed unit operations.

a. Training should also increase proficiency/familiarization in the use of applicable automation systems such as TAMMIS, CHCS, PARRTS, and related automation skills such as data transfer, spreadsheet/database usage, and medical record data coding using the ICD-9-CM and CPT4.

b. Upon alert for deployment, the patient administrator of deploying TOE units will notify the Commander, USAMEDCOM, ATTN: MCHS-IS, 1216 Stanley Road, Suite 25, Fort Sam Houston, TX 78234-6025. The Chief, Statistical Quality Control Branch, CSD/PASBA, will forward the deploying units a deployment package including applicable ARs, users' manuals, and required reports.

c. Activated TOE units are responsible for submitting the monthly medical workload reports by using the forms identified in the WWR Users' Manual, by using the automated version on diskette, or by using the WWR function in TAMMIS. These reports will be forwarded directly to the Commander, USAMEDCOM, ATTN: MCHS-IS, 1216 Stanley Road, Suite 25, Fort Sam Houston, TX 78234-6025 (via post office mail or electronic mail) and are due by the 15th day of the month following the report period.

d. Patient administrators of deployed TOE units will ensure input of diagnostic and procedure codes on inpatient treatment episodes of care into TAMMIS or CHCS for electronic transfer to the Commander, USAMEDCOM, ATTN: MCHS-IS, 1216 Stanley Road, Suite 25, Fort Sam Houston, TX 78234-6025 according to schedules stated in paragraph 15-2.

15-9. Ambulatory Data System

The Ambulatory Data System (ADS) contains ambulatory health care information concerning DOD beneficiaries treated in Army MTFs. Each MTF will operate the ADS system including timely completion of applicable ADS forms, resolution of rejection reports, and the overall efficient operation of the system. The DOD Coding Hotline will provide official coding guidelines and coding assistance. The CSD/PASBA provides instruction for the frequency and distribution of reporting requirements and use of the DOD Coding Hotline.

15-10. The Army Central Registry

The Army Central Registry is a database of identified instances of child/spouse abuse. Access to either case information or statistical data must be according to AR 608-18. Program inquiries may be directed to Commander, USAMEDCOM, ATTN: MCHD-CL-H, 2050 Worth Road, Fort Sam Houston, TX 78234.

Appendix A References

Section I Required Publications

AR 1-4

Employment of Department of the Army Resources in Support of the U.S. Secret Service. (Cited in paras 3-31a and 3-37.)

AR 12-15

Joint Security Assistance Training (JSAT) Regulation. (Cited in paras 3-19a and 6-2e(1).)

AR 27-20

Claims. (Cited in paras 12-6c, 13-1c, 13-8a, and 13-8d.)

AR 37-103

Disbursing Operations for Finance and Accounting Offices. (Cited in paras 11-8f, 11-11c, and 12-4e.)

AR 40-4

Army Medical Department Facilities/Activities. (Cited in para 15-6.)

AR 40-5

Preventive Medicine. (Cited in paras 3-15a, 3-15b, 3-41b, 3-43c, 3-45c, and 10-1e.)

AR 40-29/AFR 160-13/NAVMEDCOMINST 6120.2A/CGCOMDTINST M6120.8B

Medical Examinations of Applicants for United States Service Academies, Reserve Officer Training Corps (ROTC) Scholarship Programs, Including Two-and-Three-Year College Scholarship Program (CSP), and the Uniformed Services University of the Health Sciences (USUHS). (Cited in para 3-5.)

AR 40-57/BUMEDINST 5360.26/AFR 160-99

Armed Forces Medical Examiner System. (Cited in para 6-5a.)

AR 40-63/NAVMEDCOMINST 6810.1/AFR 167-3

Ophthalmic Services. (Cited in paras 3-12a, 3-23a(4), 3-24b(3)(c), and 10-6e(7).)

AR 40-66

Medical Record Administration and Health Care Documentation. (Cited in paras 2-4, 5-20b, 5-22d, 9-9e(1), 9-9f(4)(a), 10-11a, 14-7b, and 15-5.)

AR 40-350/AFR 168-11/BUMEDINST 6320.1E/PHS CCPM 60/COMDTINST M6320.8B/NOAAR 56-52C

Patient Regulating To and Within the Continental United States. (Cited in paras 5-5d and 5-18a.)

AR 40-501

Standards of Medical Fitness. (Cited in paras 2-8a, 2-18c, 3-2h, 3-7, 5-3b, 5-3e(1), 5-3e(2), 5-3e(3), 5-3e(4), 5-9a(1), 7-5b(5), 7-7, 7-9c, 7-9d, 7-11, 7-11a, 7-11b, 7-11d(2)(d), 7-11d(6), 7-21a(1), 8-7b(2), 8-13, and table 7-1.)

AR 40-562/AFJI 48-110/BUMEDINST 6230.15/CG COMDTINST M6230.4E

Immunizations and Chemoprophylaxis. (Cited in para 3-16c.)

AR 50-5

Nuclear and Chemical Weapons and Materiel-Nuclear Surety. (Cited in para 3-45d.)

AR 50-6

Nuclear and Chemical Weapons and Materiel-Chemical Surety. (Cited in para 3-45d.)

AR 135-200

Active Duty for Training, Annual Training and Active Duty Special Work of Individual Soldiers. (Cited in paras 3-2a(2) and 5-17c.)

AR 135–381

Incapacitation of Reserve Component Soldiers. (Cited in paras 3-2, 3-2a(2), 3-2b, 3-2j, 5-6d, 7-21a(1), and 8-12.)

AR 145–1

Senior Reserve Officers Training Corps Program: Organization, Administration, and Training. (Cited in paras 3-3a(2), 3-3b(1), 3-3b(2), 5-9a(3), 5-9b(3), and 7-5b(6)(a).)

AR 145–2

Junior Reserve Officer Training Program. (Cited in para 5-9b(3).)

AR 190–47

The Army Corrections System. (Cited in paras 3-38b(3), 5-13a(5), and 5-13b.)

AR 215–1

Nonappropriated Fund Instrumentalities and Morale, Welfare, and Recreation Activities. (Cited in para 3-15a.)

AR 335–15

Management Information Control System. (Cited in paras 3-19, 5-16e, and 6-1.)

AR 500–60

Disaster Relief. (Cited in para 3-65.)

AR 600–8–1

Army Casualty Operations/Assistance/Insurance. (Cited in paras 6-2a(4), 6-2c, 6-2c(2), 6-2d, 6-2e(1), 6-4a, 6-5a, 9-9e(3), and 9-9f(4)(b).)

AR 600–8–10

Leaves and Passes. (Cited in para 2-8a and 5-1e.)

AR 600–8–24

Officer Transfers and Discharges. (Cited in paras 2-10, 3-11, 5-1c, 5-5h(1), 5-6c, 5-17c, and 7-5b(8).)

AR 600–8–105

Military Orders. (Cited in paras 5-5i and 8-4c(6)(b).)

AR 600–20

Army Command Policy. (Cited in paras 2-9, 2-12h, and 4-1a.)

AR 600–85

Alcohol and Drug Abuse Prevention and Control Program. (Cited in paras 3-15a and 5-18a(4)(b).)

AR 601–100

Appointment of Commissioned and Warrant Officers in the Regular Army. (Cited in para 3-7.)

AR 608–1

Army Community Service Program. (Cited in para 3-52b.)

AR 608–18

The Army Family Advocacy Program. (Cited in para 15-10.)

AR 614–100

Officers Assignment Policies, Details and Transfers. (Cited in paras 8-8 and 8-8d(6).)

AR 614–200

Enlisted Assignments and Utilization Management. (Cited in paras 8-8, 8-8b, and 8-8d(6).)

AR 635–5

Separation Documents. (Cited in paras 5-18a(3)(b) and 5-18a(3)(c).)

AR 635–10

Processing Personnel for Separation. (Cited in paras 5-18a(3)(b), and 8-7b(5).)

AR 635–40

Physical Evaluation for Retention, Retirement, or Separation. (Cited in paras 2-6c, 3-2c, 5-2d, 5-3d, 5-3e(2), 5-5h(2), 5-8d, 5-13e, 5-17b(2), 5-18a(3)(a), 6-2a(3)(f), 7-1, 7-5b(9), 7-10, 7-11, 7-21a(1), 7-22, 7-23, 8-4d(5), 8-9a, and table 7-1.)

AR 635–200

Enlisted Personnel. (Cited in paras 2-10, 3-11, 5-1c, 5-3e(3), 5-5h(1), 5-6c, 5-17b(1), 5-17c, 7-5b(8), 7-11, 7-11d(10), and 8-11.)

AR 638–2

Care and Disposition of Remains and Disposition of Personal Effects. (Cited in paras 4-5c, 6-4a, 6-4b, and 6-4d.)

AR 700–84

Issue and Sale of Personal Clothing. (Cited in paras 4-5d and 8-5c.)

AR 930–5

American National Red Cross Service Program and Army Utilization. (Cited in para 3-42a.)

DFAS–IN Regulation 37–1

Finance and Accounting Policy Implementation. (Cited in paras 3-22 and 14-12.)

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised

This publication is available from the American Psychiatric Press, Inc., 1400 K Street, N.W., Suite 1101, Washington, DC 20005. (Cited in para 7-24b(6)(c).)

DOD 7000.14–R, Vol 1

Financial Management Regulation, Volume 1, General Financial Management Information, Systems and Requirements. (Cited in paras 3-22 and 11-9.)

DOD 7000.14–R, Vol 4

Financial Management Regulation, Volume 4, Accounting Policy and Procedures. (Cited in paras 3-22 and 14-8a.)

DOD 7000.14–R, Vol 11A

Financial Management Regulation, Volume 11A, Reimbursable Operations, Policy and Procedures. (Cited in para 3-22.)

IPDS Users Manual

Individual Patient Data System Users' Manual. (Cited in para 13-3b(3).) (Copies of this publication may be obtained from Commander, PASBA, ATTN: MCHI-QZ, 1216 Stanley Road, Fort Sam Houston, TX 78234-6070.)

Medical Services Account Users Manual

This manual can be obtained from the Commander, USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Fort Sam Houston, TX 78234-6010. (Cited in paras 4-6a, 11-1c, 11-13, and 12-1.)

VA Physicians Guide for Disability Evaluation Examinations

This publication is available as part of the Automated Medical Information Exchange application of the Decentralized Hospital Computer Program software. This program is available on CD-ROM from the Albany Information Resource Management Field Office, Department of Veteran's Affairs, 2 Third Street, Frear Building, Suite 301, Troy, NY 12180. (Cited in para 7-20.)

WWR Users Manual

Worldwide Workload Reporting Users' Manual. (Cited in paras 15-6 and 15-8c.) (This manual can be obtained from Commander, USAMEDCOM, ATTN: MCHI-IS, 1216 Stanley Road, Suite 25, Fort Sam Houston, TX 78234-6025.)

Section II**Related Publications**

A related publication is merely a source of additional information. The user does not have to read it to understand this publication.

ABCA QSTAG 470

Documentation Relative to Medical Evacuation, Treatment, and Cause of Death of Patients. (This publication may be obtained from the DOD Single Stock Point, Code 3015, 5801 Tabor Avenue, Philadelphia, PA 19120-5099.)

AR 11-2

Management Control

AR 11-7

Internal Review and Audit Compliance Program

AR 15-6

Procedures for Investigating Officers and Board of Officers

AR 25-400-2

The Modern Army Recordkeeping System

AR 27-50

Status of Forces Policies, Procedures, and Information

AR 36-2

Audit Reports and Followup

AR 36-5

Auditing Service in the Department of the Army

AR 40-3

Medical, Dental, and Veterinary Care

AR 40-38

Clinical Investigation Program

AR 40-68

Quality Assurance Administration

AR 70-25

Use of Volunteers as Subjects of Research

AR 190-8

Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detainees

AR 190-57

Civilian Internees-Administration, Employment, and Compensation

AR 210-174

Accounting Procedures for Prisoners' Personal Property and Funds

AR 351-3

Professional Education and Training Programs of the Army Medical Department

AR 360-5

Army Public Affairs, Public Information

AR 380-49

Industrial Security Program

AR 385-10

The Army Safety Program

AR 600-8

Military Personnel Management

AR 600-8-6

Personnel Accounting and Strength Reporting

AR 600-8-14

Identification Cards for Members of the Uniformed Services, their Family Members, and other Eligible Personnel

AR 600-8-104

Military Personnel Information Management/Records

AR 600-9

The Army Weight Control Program

AR 600-60

Physical Performance Evaluation System

AR 633-30/AFR 125-30

Military Sentences to Confinement

AR 735-5

Policies and Procedures for Property Accountability

DA Pam 27-1

Treaties Governing Land Warfare

DA Pam 27-162

Claims Procedures

DOD 6010.8-R

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

DOD 6010.15-M

Military Treatment Facility Uniform Business Office (UBO). (This publication may be obtained from the Commander, USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Fort Sam Houston, TX 78234-6010.)

DOD Directive 6010.16

Armed Forces Medical Examiner System

DOD Instruction 6015.23

Delivery of Health Care at Military Treatment Facilities (MTFs)

FM 8-230

Medical Specialist

Federal Benefits for Veterans and Dependents

This pamphlet can be obtained from the VA Office of Public Affairs (80D), 810 Vermont Ave., NW, Washington, DC, 20008 or from any VA medical facility.

ICD-9-CM

International Classification of Diseases (ICD)-Ninth Revision-Clinical Modification. (Copies of this 3-volume set may be obtained from the Superintendent of Documents, Government Printing Office, Washington, DC 20402-9325.)

Joint Commission on Accreditation of Healthcare Organizations Accreditation Manual for Hospitals

This manual may be obtained from the Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Boulevard, Oakbrook Terrace, IL 60181.

Joint Federal Travel Technical Messages 5-93, 7-93, and 7-97 JFTR, Vol 1

Joint Federal Travel Regulation-Uniformed Service Members, paragraphs U7550-6, U7950, and U7951

Misc Pub 27-7

Manual for Courts-Martial, United States, 1995 edition

NATO STANAG 2061

Procedures for Disposition of Allied Patients by Medical Installations. (NATO STANAGs may be obtained from the DOD Single Stock Point, Code 3015, 5801 Tabor Avenue, Philadelphia, PA 19120-5099.)

NATO STANAG 2101

Principles and Procedures for Establishing Liaison

NATO STANAG 2132

Documentation Relative to Medical Evacuation, Treatment, and Cause of Death of Patients

NATO STANAG 3113

Provision of Support to Visiting Personnel, Aircraft, and Vehicles

NGR 40-400

Patient Administration for Members of the Army National Guard

NGR 40-501

Medical Examination for Members of the Army National Guard

RCS MED-363

Abortion Statistics Report

SOLOG 74

Standardization of Certain Aspects of Operations and Logistics

TM 8-300/NAVMED P-5065/AFM 160-19

Autopsy Manual

VASRD

Veteran's Administration Schedule for Rating Disabilities. (This publication is available on the VA web site or by writing to the Department of Veteran's Affairs, ATTN: Directives, Forms, and Records Staff, 810 Vermont Avenue NW, Washington, DC 20420.)

Waddell G., McCulloch J.A., Kummel E., Venner R.M. Non-organic physical signs in low back pain. *Spine*. 1980; 5:117-125.

Waddell G., Somerville D., Henderson I., Newton M. Objective clinical evaluation of physical impairment in chronic low back pain. *Spine*. 1992; 17:617-628.

Section III**Prescribed Forms****DA Form 2631**

Medical Care-Third Party Liability Notification. (Prescribed in paras 13-1f, 13-3b(2), and 13-6.)

DA Form 2984

Very Seriously Ill/Seriously Ill/Special Category Patient Report. (Prescribed in para 6-2b(1).)

DA Form 2985

Admission and Coding Information. (Prescribed in paras 4-6c and 13-3b.)

DA Form 3153

Medical Service Account Patient Ledger Card. (Prescribed in para 11-9.)

DA Form 3154

MSA Invoice and Receipt. (Prescribed in paras 11-7a and 11-9.)

DA Form 3155

MSA Cash Record. (Prescribed in para 11-9.)

DA Form 3647

Inpatient Treatment Record Cover Sheets. (Prescribed in paras 13-3b(3) and 13-5b.)

DA Form 3647-1

Inpatient Treatment Record Cover Sheet (for Plate Imprinting). (Prescribed in para 13-3b(3).)

DA Form 3648

Coding Transcript-Individual Patient Data System. (Prescribed in para 4-6a.)

DA Form 3696

Patient's Deposit Record. (Prescribed in paras 12-4a, 12-7, and 12-9.)

DA Form 3821

Report of Administrative Officer of the Day. (Prescribed in para 6-2a.)

DA Form 3894

Hospital Report of Death. (Prescribed in para 6-4a.)

DA Form 3910

Death Tag. (Prescribed in para 6-4b.)

DA Form 3929

MSA-Accounts Receivable Register and Control Ledger. (Prescribed in para 11-9.)

DA Form 3947

Medical Evaluation Board Proceedings. (Prescribed in paras 7-8a, 7-8b, and 7-9.)

DA Form 3981

Transfer of Patient. (Prescribed in para 2-13.)

DA Form 3983

Patients' Trust Fund-Authorization for Deposit or Withdrawal of Funds and Valuables. (Prescribed in para 12-7.)

DA Form 4029

Patient Clearance Record. (Prescribed in para 4-6c.)

DA Form 4128

Patient's Trust Fund Journal. (Prescribed in paras 12-4a, 12-5h, and 12-7.)

DA Form 4159

Request for Medical Care in a Federal Medical Treatment Facility Outside Department of Defense. (Prescribed in paras 9-5 and 9-7.)

DA Form 4160

Patient's Personal Effects and Clothing Record. (Prescribed in paras 4-4 and 4-5.)

DA Form 4665

Patients' Trust Fund-Daily Summary Record. (Prescribed in para 12-7.)

DA Form 4707

Entrance Physical Standards Board (EPSBD) Proceedings. (Prescribed in paras 7-11a, 7-11c(4), and 7-11d.)

DD Form 7

Report of Treatment Furnished Pay Patients: Hospitalization Furnished (Part A). (Prescribed in paras 3-21b(3), 3-24b(3)(c), 3-24c, 3-25a(2), 3-25a(3), 3-30a, 3-30b, 3-31b, 3-33e, 3-34, 3-38c, 3-41c, 3-47b, and 11-9.)

DD Form 7A

Report of Treatment Furnished Pay Patients: Outpatient Treatment Furnished (Part B). (Prescribed in paras 3-23a(4), 3-24b(1)(a), 3-24b(3)(c), 3-24c, 3-25a(2), 3-25a(3), 3-30a, 3-30b, 3-31a, 3-31b, 3-32c, 3-33e, 3-34, 3-38c, 3-41c, 3-47b, and 11-9.)

DD Form 599

Patient's Effect Storage Tag. (Prescribed in para 4-5.)

DD Form 675

Receipt for Records and Patients Property. (Prescribed in para 5-18a(6)(a).)

Section IV

Referenced Forms

DA Form 2-1

Personnel Qualification Record-Part II

DA Form 11-2-R

Management Control Evaluation Certification Statement

DA Form 1863-1

Services and or Supplies Provided by Civilian Hospitals

DA Form 2173

Statement of Medical Examination and Duty Status

DA Form 3349

Physical Profile

DA Form 4359-R

Authorization for Psychiatric Service Treatment

DA Form 5009-R

Medical Record-Release Against Medical Advice

DD Form 2(RET)

United States Uniformed Services Identification Card (Retired)

DD Form 2A(ACT)

Active Duty Military ID Card

DD Form 139

Pay Adjustment Authorization

DD Form 214

Certificate of Release or Discharge from Active Duty

DD Form 256A

Honorable Discharge Certificate

DD Form 257A

General Discharge Certificate (Under Honorable Conditions)

DD Form 689

Individual Sick Slip

DD Form 771

Eyewear Prescription

DD Form 1131

Cash Collection Voucher

DD Form 1173

Uniformed Services Identification and Privilege Card

DD Form 1380
US Field Medical Card

DD Form 2527
Statement of Personal Injury-Possible Third Party Liability-CHAMPUS

DD Form 2569
Third Party Collection Program-Insurance Information

DD Form 2570
Third Party Collection Program-Report on Program Results

DD Form 2571
Third Party Collection Program-Aging Report

DD Form 2770
Abbreviated Medical Record

DOL Form CA 16
Authorization of Examination and/or Treatment

HCFA Form 1450
Billing Statement. (This form may be obtained from the nearest local Health and Human Services Health Care Financing Administration or accessed on the HCFA.gov web site.)

HCFA Form 1500
Health Insurance Claim Form. (This form may be obtained from the nearest local Health and Human Services Health Care Financing Administration.)

OF 522
Medical Record-Request for Administration of Anesthesia and for Performance of Operations and Other Procedures

PHS Form 1866-1
Commissioned Officers Identification Card-Active Duty

PHS Form 1866-2
Commissioned Officers Identification Card-Inactive Reserve

SF 88
Report of Medical Examination

SF 93
Report of Medical History

SF 502
Medical Record-Narrative Summary

SF 503
Clinical Record-Autopsy Protocol

SF 523
Clinical Record-Authorization for Autopsy

SF 523A
Medical Record-Disposition of Body

SF 603
Health Record-Dental

SF 603A

Health Record-Dental-Continuation

SF 1034 and 1034A

Public Voucher for Purchases and Services Other than Personal

SF 1080

Voucher for Transfer Between Appropriations and/or Funds

UB-92

Uniform Bill. (This form can be obtained from the Standard Register Company, Forms Division, through local civilian business forms suppliers.)

VA Form 10-10

Application for Medical Benefits. (VA forms may be obtained from the field station having jurisdiction.)

VA Form 10-10M

Medical Certificate and History

VA Form 10-1204

Referral for Community Nursing Home Care

VA Form 21-526

Veterans Application for Compensation or Pension

Appendix B**Persons Authorized Care at Army MTFs**

Table B-1 serves as a quick reference for personnel who admit and bill patients at Army MTFs. (Notes and definitions not defined in the glossary are at the end of the appendix.)

Note. Updated charges can be found in the MSA table of CHCS. Figure B-1 identifies abbreviations used in the table.**Table B-1
Persons Authorized Care at Army MTFs**

| Paragraph | Class of Patient | Patient Category Codes | Charges | | Collect | Report required for central reimbursement | Hearing aids, prostheses, spectacles, or orthopedic footwear |
|--|--|------------------------|---------------------------|---|---|---|---|
| | | | Inpatient or Sub-sistence | Outpatient or Immunization | | | |
| Section I. Members of the Uniformed Services | | | | | | | |
| 3-1 and 3-2 | Members of the USA, USN, USAF, and USMC (including IETs) serving on AD or ADT. | A11, N11, F11, M11 | Subsistence only. | None while on AD. FRR for RC members after training period ends unless care is specifically authorized. | Enlisted Army, SF1080; all others DD139 | None. | Yes for AD members. Yes for RC members subject to limitations in paragraph 3-2. |

Table B-1
Persons Authorized Care at Army MTFs—Continued

| Paragraph | Class of Patient | Patient Category Codes | Charges | | Collect | Report required for central reimbursement | Hearing aids, prostheses, spectacles, or orthopedic footwear |
|-------------|--|--|---------------------------|---|--|---|---|
| | | | Inpatient or Sub-sistence | Outpatient or Immunization | | | |
| 3-1 | Cadets and midshipmen of USA, USN, and USAF Academies. | A14, N14, F14 | Subsistence only. | None. | From the FAO at the appropriate Service academy for USA and USAF cadets. From the Chief of Naval Personnel, Department of the Navy for midshipmen at the USNA. | None. | Yes. |
| 3-2 | RC members not on AD medical examinations. | A22, A23, N22, N23, M22, M23 | Subsistence only. | None. | Locally from the individual. | None. | No. |
| 3-3 | SROTC members with LD conditions incurred during required field training. | A21, N21, F21, M21 | Subsistence only. | None. | From RPA. | DD Form 139 | Yes, subject to limitations in paragraph 3-3. |
| 3-1 and 3-2 | Members of other Uniformed Services (USCG and the commissioned corps of the PHS and the NOAA) serving on AD, ADT, and IDT, including cadets at the USCG Academy. | C11, C12, C14, C22, P11, P12, P22, B11 | IAR. | IAR as appropriate for USCG and PHS members. None for others. | From the PHS. | DD Form 7/7A | Yes for those on AD. Yes for those not on AD subject to limitations in paragraph 3-2. |

Section II. Applicants

| | | | | | | | |
|-----|---|-------------------------|---|-------|--|--------------|-----|
| 3-4 | Designated applicants for enrollment in SROTC programs. | A21, N21, F21, M21 | Subsistence only. | None. | Locally from RPA. | DD139 | No. |
| 3-5 | Applicants for cadetship at Services academies and ROTC Scholarship applicants. | A14, N14, F14, M14, A26 | Subsistence only for applicants for USMA, USNA, and USAFA. For others, IAR. | None. | Locally from MPA for USMA, USNA, and USAFA. Report all others to USAMED-COM. | DD Form 7/7A | No. |

Table B-1
Persons Authorized Care at Army MTFs—Continued

| Paragraph | Class of Patient | Patient Category Codes | Charges | | Collect | Report required for central reimbursement | Hearing aids, prostheses, spectacles, or orthopedic footwear |
|-----------|---|--|---------------------------|----------------------------|---|---|--|
| | | | Inpatient or Sub-sistence | Outpatient or Immunization | | | |
| 3-6 | Applicants for enlistment or reenlistment in U.S. Armed Forces including applicants for enlistment in the RC. | A13, A26, N13, N26, F13, F26, M13, M26 | Subsistence only. | None. | Locally from MPA, RPA, or NGPA. | SF1080 | No. |
| 3-7 | Applicants for appointment in the RA and RC, including RC members applying for AD. | A26, N26, F26, M26 | Subsistence only. | None. | Locally from the military agency. | SF1080 | No. |
| 3-8 | Applicants who suffer injury or acute illness. | A26, N26, F26, M26 | Subsistence only. | None. | Locally from the military agency for category of applicant. | SF1080 | No. |

Section III. Retired Members of the Uniformed Services

| | | | | | | | |
|-----|---------------------------|--------------------|---|--|---|---------------|------|
| 3-9 | Retired officers. | A31, N31, F31, M31 | Subsistence only for USA, USN, USMC, and USAF officers. | IAR or immunization rate for PHS members. None for others. | Collect subsistence from officers. For other than USA, USN, USMC, and USAF, report to USAMED-COM. | DD Form 7/7A. | Yes. |
| 3-9 | Retired enlisted members. | A31, N31, F31, M31 | None for USA, USN, USMC, and USAF Rate A-1 or E-1 for all others. | IAR or immunization rate for PHS members. None for others. | Report PHS members to USAMED-COM. | DD Form 7/7A. | Yes. |

Section IV. Family Members of Uniformed Service Personnel

| | | | | | | | |
|------|--|--|--|---|--|---------------|---|
| 3-11 | Family members of AD and retired members and of persons who died while on AD or in a retired status. | A41, A43, N41, N43, F41, F43, M41, M43, A45, A47, N45, N47, F45, F47, M45, M47 | FMR for family members of USA, USN, USMC and USAF members. IAR for others. | FMR or IAR for PHS family members. None for others. | Report PHS family members to USAMED-COM. | DD Form 7/7A. | Artificial limbs and eyes only. (See note 1.) |
|------|--|--|--|---|--|---------------|---|

Table B-1
Persons Authorized Care at Army MTFs—Continued

| Paragraph | Class of Patient | Patient Category Codes | Charges | | Collect | Report required for central reimbursement | Hearing aids, prostheses, spectacles, or orthopedic footwear |
|-----------|-----------------------------|------------------------|--|----------------------------|--------------------------|---|--|
| | | | Inpatient or Sub-sistence | Outpatient or Immunization | | | |
| 3-50 | Noneligible newborn infants | K99 | FRR or as prescribed by designee status. | None. | Locally from individual. | None. | No. |

Section V. Federal Civilian Employees and Their Family Members

| | | | | | | | |
|------|--|--------------------|--|-------|-----------------------------------|-------|-----|
| 3-14 | Federal civilian employees (limited to disability retirement physicals). | K53 | Subsistence only. (See note 2.) | None. | Locally from the military agency. | None. | No. |
| 3-15 | Civilian employees authorized occupational health services. | K53 | Subsistence only. (See notes 2 and 3.) | None. | Locally from individual. | None. | No. |
| 3-15 | Civilian employees provided treatment for alcoholism. | K53 | IAR. FRR in CONUS. (See note 4.) | None. | Locally from individual. | None. | No. |
| 3-16 | Civilian employees and their family members outside the U.S. and at remote installations in CONUS. | K53, K54, K55, K56 | IAR. | IAR. | Locally from individual. | None. | No. |
| 3-17 | Department of Interior employees stationed in American Samoa and their family members. | K53, K54 | IAR. | IAR. | Locally from individual. | None. | No. |

Section VI. Foreign Nationals

| | | | | | | | |
|------|---|----------|--------------------|--------------------|---|-------------|------|
| 3-15 | NAF civilian employees | K53 | IAR. (See note 7.) | IAR. (See note 7.) | Collect locally from authorizing agency | None. | No. |
| 3-18 | Foreign military members of NATO nations in the U.S., including NATO IMET; foreign military members in the U.S. under DOD sponsorship; Partnership For Peace, and foreign military members in the U.S. in a status officially recognized by DA. | K71, K72 | FRR. | None. | Subsistence only from member. Report all other charges to USAMED-COM. | DD Form 7A. | Yes. |

Table B-1
Persons Authorized Care at Army MTFs—Continued

| Paragraph | Class of Patient | Patient Category Codes | Charges | | Collect | Report required for central reimbursement | Hearing aids, prostheses, spectacles, or orthopedic footwear |
|-----------|---|------------------------|---------------------------|----------------------------|---|---|--|
| | | | Inpatient or Sub-sistence | Outpatient or Immunization | | | |
| 3-18 | NATO family members of foreign personnel. | K73 | FRR. | None. | Locally from individual or sponsor. | DD Form 7A unless collected locally. | No. (See note 4.) |
| 3-18 | Foreign civilians accompanying military personnel of NATO nations and their family members. | K76, K77 | FRR. | FRR. | Locally from individual. | None. | No. |
| 3-18 | IMET trainees | K71 | IMET. | IMET. | | | |
| 3-18 | Family members of IMET military trainees except NATO IMET. | K75 | FRR. | FRR. | Locally from individual or sponsor. | None. | No. (See note 5.) |
| 3-18 | NATO IMET trainees, both military and civilian. | K71 | IMET. | None. | Collect subsistence locally from officers and civilians. Report all others to USAMED-COM. | DD Form 7/7A. | Yes. |
| 3-18 | Family members of NATO IMET. | K75 | FRR. | None. | Locally from individual or sponsor. | None. | No (See note 4.) |
| 3-18 | FMS trainees. | K71 | FRR. | FRR. | Collect subsistence locally. Report all others to USAMED-COM. | DD Form 7/7A. | Yes. |
| 3-18 | Family members of FMS trainees. | K75 | FRR. | FRR. | Locally from individual or sponsor. | None. | No. (See note 4.) |
| 3-18 | Foreign nationals who provide direct service to U.S. Armed Forces. | K74 | FRR. | FRR. | Locally from individual when applicable. | None. | No. |
| 3-18 | Special nationals | K74 | FLEX | FRR. | Locally from individual when applicable. | None. | Yes. |
| 3-18 | KATUSA | K74 | None. | None. | None. | None. | Yes. |
| 3-18 | Foreign national in the U.S. on IMET orientation tours. | K71 | IMET. | IMET. | Locally from authorizing agency. | DD Form 7/7A. | No. |
| 3-20 | Liaison personnel from NATO Army force OCONUS. | K72 | SR. | None. | Collect subsistence locally from individual. | DD Form 7. | Yes. |

Table B-1
Persons Authorized Care at Army MTFs—Continued

| Paragraph | Class of Patient | Patient Category Codes | Charges | | Collect | Report required for central reimbursement | Hearing aids, prostheses, spectacles, or orthopedic footwear |
|--|---|------------------------|--|----------------------------|--|---|--|
| | | | Inpatient or Sub-sistence | Outpatient or Immunization | | | |
| 3-20 | Crews and passengers of NATO that land at U.S. or allied airfields OCONUS. | K72 | FRR. | None. | Collect subsistence locally from individual. Report others to USAREUR. | DD Form 7. | No. |
| Section VII. Beneficiaries of Other Federal Agencies | | | | | | | |
| 3-23 | VA beneficiaries. | K61 | IAR. | IAR. | Collect locally from authorizing agency | DD Form 7/7A. | Yes. |
| 3-24 | OWCP beneficiaries. | K62 | IAR. | IAR. | Collect locally from authorizing agency. | DD Form 7/7A supported by CA Form 16. | Yes. |
| 3-25 | PHS beneficiaries a. Native Americans and Alaska natives in Alaska. | K67 | IAR. | IAR. | Collect locally from authorizing agency. | DD Form 7/7A, SF 1080. | No. |
| | b. Inactive reserve PHS commissioned officers (limited to medical exams and immunizations). | P22 | IAR when hospitalization is needed for examinations. | IAR. | Collect locally from authorizing agency. | DD Form 7/7A, SF 1080. | No. |
| | c. AD non-commissioned officers and crews of NOAA vessels (limited to emergency or specifically authorized care). | B11 | IAR. | IAR. | Collect locally from authorizing agency. | DD Form 7/7A, SF 1080. | No. |
| 3-26 | Selective Service System beneficiaries (Registrants). | A26, N26, F26, M26 | SR. | None. | Collect locally from authorizing agency. | DD Form 7/7A, SF 1080. | No. |
| 3-27 | Beneficiaries of the Department of State Medical Program. | | | | | | |

Table B-1
Persons Authorized Care at Army MTFs—Continued

| Paragraph | Class of Patient | Patient Category Codes | Charges | | Collect | Report required for central reimbursement | Hearing aids, prostheses, spectacles, or orthopedic footwear |
|-----------|--|------------------------|---------------------------|----------------------------|---|--|--|
| | | | Inpatient or Sub-sistence | Outpatient or Immunization | | | |
| | a. Officers and employees and family members outside the United States and after MEDEVAC to the U.S. | K51, K52 | IAR. | IAR. | Locally from authorizing office for in-patient care. Outpatient care for employees of the Department of State will be billed monthly to the address in footnote. (See note 6.) Same as above. | SF 1080, DD Form 7A, and letter of authorization for medical care. | No. |
| | b. Applicants for appointment to foreign service posts (limited to medical exams and immunizations). | K69 | — | IAR. | Same as above. | Same as above. | No. |
| | c. Officers, employees, applicants and family members of officers and employees in the U.S. | K53, K54 | — | IAR. | Same as above. | Same as above. | No. |
| | d. Officers, employees, applicants, and family members of officers and employees outside the United States when care is not covered under the Department of the State Medical Program. | K51, K52 | FRR. | FRR. | Locally from individual. | None | No. |
| 3-28 | Peace Corps Personnel. | | | | | | |
| | a. Outside the U.S. | | | | | | |
| | (1) Volunteers, volunteer leaders, and their family members. | K69 | IAR. | IAR. | Locally from authorizing office. | SF 1080 supported by DD Form 7/7A. | No. |
| | (2) Employees and their family members who are beneficiaries of the Peace Corps. | K69 | IAR. | IAR. | Locally from individual. | None. | No. |
| | (3) Peace Corps applicants. | K69 | IAR. | IAR. | Locally from individual. | None. | No. |
| | b. Inside the U.S. | | | | | | |
| | (1) Peace Corps applicants. | K69 | IAR. | IAR. | Locally from individual. | None. | No. |

Table B-1
Persons Authorized Care at Army MTFs—Continued

| Paragraph | Class of Patient | Patient Category Codes | Charges | | Collect | Report required for central reimbursement | Hearing aids, prostheses, spectacles, or orthopedic footwear |
|-----------|--|------------------------|---|----------------------------|--|---|--|
| | | | Inpatient or Sub-sistence | Outpatient or Immunization | | | |
| | (2) Volunteers, volunteer leaders, and their family members. (3) Peace Corps volunteers evacuated from stations in the South Pacific provided care at TAMC. | K69 K69 | IAR. IAR. | IAR. IAR. | Locally from individual. Locally from individual. | None. None. | No. No. |
| 3-29 | Members of the U.S. Soldiers' and Airmen's Home. | K63 | FSR when hospitalized as beneficiary of the Home. | None. | Report to USAMED-COM. | SF 1080. | No. |
| 3-30 | Department of Justice beneficiaries. a. FBI agents. | K53 | IAR. | IAR. | Collect locally from authorizing agency. | DD Form 7/7A. | No. |
| | b. Claimants whose claims are administered by the Department of Justice. | K53 | IAR. | IAR. | Collect locally from authorizing agency. | DD Form 7/7A. | No. |
| 3-31 | Treasury Department beneficiaries. a. Secret Service agents. | K53 | IAR. | IAR. | Collect locally from authorizing agency. | DD Form 7/7A | No. |
| | b. Agents of U.S. Customs Service and their prisoners. | K53 | IAR. | IAR. | Collect locally from authorizing agency. | DD Form 7/7A | No. |
| 3-32 | Federal Aviation Agency air traffic controllers. | K53 | IAR. | IAR. | Collect locally from authorizing agency. | DD Form 7/7A, SF 1080. | No. |
| 3-33 | Job Corps and VISTA beneficiaries. a. Job Corps applicants for enrollment and VISTA applicants for employment. | K69 | IAR. | IAR. | Collect locally from authorizing agency. | DD Form 7/7A, SF 1080. | No. |
| | b. Job Corps enrollees and VISTA personnel. | K69 | IAR. | IAR. | Collect locally from authorizing agency. | DD Form 7/7A, SF 1080. | No. |

Table B-1
Persons Authorized Care at Army MTFs—Continued

| Paragraph | Class of Patient | Patient Category Codes | Charges | | Collect | Report required for central reimbursement | Hearing aids, prostheses, spectacles, or orthopedic footwear |
|--|--|------------------------|---------------------------|----------------------------|---|---|--|
| | | | Inpatient or Sub-sistence | Outpatient or Immunization | | | |
| 3-34 | Social Security Administration beneficiaries. | K64 | IAR. | IAR. | Collect locally from financial intermediary as primary and the individual for any unpaid balance. | DD Form 7/7A, SF 1080, and UB-92. | No. |
| 3-35 | Micronesian citizens (when referred for specialized treatment). | K68 | IAR. | IAR. | Locally from respective island governmental agencies. | SF 1080 with DD Form 7/7A. | No. |
| Section VIII. Miscellaneous Categories of Eligible Personnel | | | | | | | |
| 3-36 | American Samoan citizens (when referred for specialized treatment). | K68 | IAR. | IAR. | Locally from the LBJ Tropical Medical Center, Pago-Pago, American Samoa 96799. | SF 1080 with DD Form 7/7A. | No. |
| 3-37 | Secret Service protectees and protectors. | K69 | IAR. | IAR. | None. Report to local MEDDAC for inclusion on quarterly report. | DD Form 7/7A. | No. |
| 3-38 | Persons in military custody and nonmilitary Federal prisoners. | | | | | | |
| | a. POWs in time of war. | K78 | None. | None. | Locally from MPA. | None. | Yes. |
| | b. Retained personnel and internees. | K66 | None. | None. | Locally from MTF operating funds. | None. | Yes. |
| | c. Military prisoners whose punitive discharge has been executed but whose sentence has not expired. | K66 | SR only. | None. | Locally from MTF operating funds. | None. | Yes. |
| | d. Military prisoners hospitalized beyond expiration of sentence. | K66 | FRR. | FRR. | Locally from individual. | None. | No. |
| | e. Nonmilitary Federal prisoners (emergency care only). | K66 | IAR. | IAR. | Collect locally from authorizing agency. | DD Form 7/7A; SF 1080. | No. |
| 3-39 | Former female members of the Armed Forces. | A27, N27, F27, M27 | SR only. | None. | Locally from individual. | None. | No. |

Table B-1
Persons Authorized Care at Army MTFs—Continued

| Paragraph | Class of Patient | Patient Category Codes | Charges | | Collect | Report required for central reimbursement | Hearing aids, prostheses, spectacles, or orthopedic footwear |
|-----------|--|------------------------|---------------------------|----------------------------|--|---|--|
| | | | Inpatient or Sub-sistence | Outpatient or Immunization | | | |
| | Newborn infants of former female members of the Armed Forces. | K99 | FRR. | None. | Locally from individual. | None. | No. |
| 3-40 | Persons whose military records are being considered for correction. | K99 | SR only. | None. | Locally from individual. | None. | No. |
| 3-41 | Civilian Seamen a. Military Sealift Command (1) Occupational Health | K53 | SR only. | None. | Collect locally from authorizing agency. Report to USAMED-COM. | DD Form 7/7A; SF 1080 | No. |
| | (2) OWCP | K62 | IAR. | IAR. | | None. | No. |
| | b. Crews of Ships of United States registry. (1) Emergency only | K69 | FRR. | FRR. | Report to USAMED-COM. | DD Form 7/7A. | |
| | (2) OWCP | K62 | IAR. | IAR. | | | |
| 3-42 | Red Cross personnel and their family members a. Outside the United States. Uniformed and nonuniformed full-time, paid professional field and headquarters staff; administrative and supervisory personnel; field directors; assistant field directors and staff assistants; and uniformed, full-time paid clerical and secretarial workers. | K69 | Subsistence only. | None. | Locally from individual or sponsor. | None. | No. |

Table B-1
Persons Authorized Care at Army MTFs—Continued

| Paragraph | Class of Patient | Patient Category Codes | Charges | | Collect | Report required for central reimbursement | Hearing aids, prostheses, spectacles, or orthopedic footwear |
|-----------|---|------------------------|---------------------------|----------------------------|--|---|--|
| | | | Inpatient or Sub-sistence | Outpatient or Immunization | | | |
| | b. In the United States. Care may be provided in emergencies and for injuries sustained in the performances of duties at a Uniformed Services facility. | | FRR. | FRR. | Locally from individual or sponsor. | None. | No. |
| 3-43 | Civilian student employees. | K69 | SR only. | None. | Locally from individual. | None. | No. |
| 3-44 | Civilian contractor employees. a. Civilian employees of U.S. Government contractors outside the United States and their family members. | K65 | FRR. | FRR. | Locally from contractor. | None. | No. |
| 3-45 | b. Civilian employees of DOD contractors—examinations only. | K65 | SR only. | None. | Locally from individual. | None. | No. |
| 3-44 | c. U.S. contractor civilian employees stationed in American Samoa CARE AT TAMC ONLY. | K65 | FRR. | FRR. | Locally from individual. | None. | No. |
| 3-45 | d. Civilian employees of DoD contractors of nuclear and chemical surety programs. | K65 | FRR. | FRR. | Locally from individual. | None. | No. |
| 3-46 | Civilian participants in Army-sponsored activities. | K69 | SR only. | None. | Locally from individual. | None. | No. |
| 3-47 | Claimants. a. Claimant whose claims are administered by DOD. | K82, K83, K84 | None. | None. | None. | None. | No. |
| | b. Claimants whose claims are administered by other Federal Departments. | K64 | IAR. | IAR. | Collect locally from authorizing agency. | DD Form 7/7A, SF 1080. | No. |
| | c. Beneficiaries of private relief bills. | K69 | None. | None. | None. | None. | — |

Table B-1
Persons Authorized Care at Army MTFs—Continued

| Paragraph | Class of Patient | Patient Category Codes | Charges | | Collect | Report required for central reimbursement | Hearing aids, prostheses, spectacles, or orthopedic footwear |
|-----------|--|---------------------------|---|-------------------------------|--|---|--|
| | | | Inpatient or Sub-sistence | Outpatient or Immunization | | | |
| 3-48 | Persons outside the U.S. who provide direct services to the U.S. Armed Forces. a. Civilian representatives of various groups. b. USO professional personnel and family members. c. Educational representatives of recognized educational institutions and their family members. | K69 K69 K69 | SR only. FRR. FRR. | None. FRR. FRR. | None. Subsistence from individual. Medical charges from area USO Director. Locally from individual. | None. None. None. | No. No. No. |
| 3-49 | American nationals covered by agreements. | K99 | FRR. | FRR. | Locally from individual. | None. | No. |
| 3-50 | Secretary of the Army designees. | K82,K81 | As prescribed in Secretary of the Army or Secretary of Defense approval or by the overseas commander concerned. | | Locally from individual when applicable. | None. | If approved. |
| 3-51 | Preadoptive children and court appointed wards. | K99 | FMR. | None. | Locally from sponsor. | None. | Artificial limbs and eyes only. |
| 3-53 | Ineligible persons outside the United States. | K92 | FRR. | FRR. | Locally from individual. | None. | No. |
| 3-54 | Individuals evacuated from one area to another. | K53 | Same as in the original area on a temporary basis until appropriate disposition can be made. | | As indicated for the specific category. | None. | No. |
| 3-55 | Civilians in emergencies. | K91 | FRR. | FRR. | Locally from individual. | None. | No. |
| 3-56 | Volunteer subjects in approved DA research project. | K82 | None. | None. | None. | None. | No. |
| 3-57 | U.S. nationals in foreign penal institutions. | K66 | | | | | |

Table B-1
Persons Authorized Care at Army MTFs—Continued

| Paragraph | Class of Patient | Patient Category Codes | Charges | | Collect | Report required for central reimbursement | Hearing aids, prostheses, spectacles, or orthopedic footwear |
|-----------|---|------------------------|--|--|--|---|--|
| | | | Inpatient or Sub-sistence | Outpatient or Immunization | | | |
| 3-58 | Domestic servants outside the United States (physical examinations and immunizations). | K79 | — | FRR. | Locally from individual. | None. | No. |
| 3-59 | U.S. contractor civilian employees stationed in American Samoa CARE AT TAMC ONLY. | K65 | FRR. | FRR. | Locally from individual. | None. | No. |
| 3-60 | Civilians injured on Army installations. | K92 | None. | None. | None. | None. | No. |
| 3-61 | Former military personnel with extended or MHSS benefits. | K99 | As determined by DODI or Congressional Instructions. | | Determined by the program. | None | No. |
| 3-62 | Returning prisoners of war and their family members. | K69 | FMR for family members of USA, USN, USMC, and USAF members. IAR for others. | FMR for PHS family members. None for others. | Report PHS family members to USAMED-COM. | DD Form 7/7A. | Artificial limbs and eyes only. (See note 1.) |
| 3-63 | Personnel who participate in organ transplant procedures (organ donors for Uniformed Services patients in Army MTFs who are not otherwise eligible for care in USMTFs). | K81, K82 | As stated in Secretary of the Army or Secretary of Defense approval in each specific case. (Also see para 3-50.) | | | None. | No. |
| 3-64 | Civilian faculty members of the USUHS. | K53 | IAR. | IAR. | Locally from individual. | None. | No. |
| 3-65 | Civilians in national or foreign disaster. | K91 | FRR. | FRR. | Locally from disaster relief agency. | None. | No. |

Table B-1
Persons Authorized Care at Army MTFs—Continued

| Paragraph | Class of Patient | Patient Category Codes | Charges | | Collect | Report required for central reimbursement | Hearing aids, prostheses, spectacles, or orthopedic footwear |
|-----------|----------------------------|------------------------|--|--|--|---|--|
| | | | Inpatient or Subsistence | Outpatient or Immunization | | | |
| 3-66 | Unremarried Former Spouses | A48, N48, F48, M48 | FMR for family members of USA, USN, USMC and USAF members. IAR for others. | FMR for PHS family members. None for others. | Report PHS family members to USAMED-COM. | DD Form 7/7A. | Artificial limbs and eyes only. (See note 1.) |

Legend for Table B-1:

FLEX — Flexible

FMR — Family Member Rate

FRR — Full (Others) Reimbursement Rate

RSR — Full subsistence rate inclusive of surcharge

FTTD — Full-time training duty

IAR — Interagency Reimbursement Rate

IET — Initial entry training

KATUSA — Korean Augmentation to the Army

MEDEVAC — Medical evacuation

MPA — Military personnel, Army (appropriation)

NGPA — National Guard Personnel, Army (appropriation)

POW — Prisoner of war

RA — Regular Army

RPA — Reserve Personnel, Army (appropriation)

SR — Subsistence rate

USA — United State Army

USAF — United State Air Force

USAFA — United States Air Force Academy

USMA — United State Military Academy

USMC — United State Marine Corps

USMTF — Uniformed Services medical treatment facility

USN — United State Navy

USNA — United State Naval Academy

USUHS — Uniformed Services University of Health Sciences

¹ Items other than artificial limbs and artificial eyes may be sold to family members outside the United States and at designated stations within the United States (para 3-12b).

² Hospitalization is authorized only when required in connection with conducting medical examinations.

³ Reimbursements made to the Army on a per capita cost basis for health services provided civilian employees (or prospective employees) of Federal departments and agencies other than the Army, except employees (or prospective employees) of the Navy, Marine Corps, and Air Force in the Washington, DC, area.

⁴ These items may be furnished on a reimbursable basis at stations within the United States that have been designated remote for purposes of furnishing such items to Uniformed Services family members.

⁵ These items may be furnished on a reimbursable basis outside the United States and at stations in the United States that have been designated remote for the purpose of furnishing such items to the US Uniformed Services family members.

⁶ For beneficiaries of the Department of State, outpatient bills will be forwarded directly by the MEDDAC to the Department of State, ATTN: Medical Services, Washington, DC 20520.

⁷ Emergency care subsistence charge only. Nonemergent follow-up occupational health or worker's compensation care for NAF employees will be billed to the employer at the IAR.

Appendix C

Management Control Evaluation Checklists

C-1. Third Party Collection Program (TPCP)

a. Purpose. The purpose of this checklist is to assist Army MTFs in evaluating the key management controls listed below. It is not intended to cover all controls.

b. Instructions. Answers must be based on the actual testing of key management controls (for example, document analysis, direct observation, sampling, simulation, other). Answers which indicate deficiencies must be explained and corrective action indicated in supporting documentation. These management controls must be evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11-2-R (Management Control Evaluation Certification Statement). A copy of DA Form 11-2-R is available on the Army Electronic Library CD-ROM (EM 0001) and on the USAPA web (<http://www.usapa.army.mil/>).

c. Test questions.

(1) Are all billable beneficiaries (family members, retirees, and family members of retirees) that are admitted and that present for emergent and non-emergent outpatient care or ancillary services interviewed for billable insurance information by appropriate personnel? Are the results of all the interviews documented on DD Form 2569, and are the forms placed on the left side of the health/medical record?

(2) Are all DD Forms 2569 indicating billable insurance reviewed and benefits/amount of coverage verified with the insurers and the results documented?

(3) Are all DD Forms 2569 indicating no billable insurance reviewed and verified against all available databases, and are identified insurance benefits/amount of coverage verified with the insurers? Are the results documented?

(4) Are procedures in place to ensure precertification/preauthorization? Is documentation and necessary information presented to the case manager on a daily basis?

(5) Are procedures in place to ensure separation of duties (that is, that personnel performing billing functions are not also performing collection functions)?

(6) Are all checks received processed, documented in a check log, stored in a safe, and deposited on a daily basis? Are all valid denials and refunds approved by the TPCP/UBO manager?

(7) Are copies of all DD Forms 2569 indicating medical care associated with an accident (including AD) forwarded to the appropriate RJA office for pursuit of medical affirmative claims?

(8) Are appropriate insurance files maintained after discharge to include DD Form 2569, assignment of benefits, and copies of the following: bills, checks received, correspondence and/or phone conversations, concurrent review and continued stay review documentation, and the explanation of benefits? Are claims files maintained for the time period and in the manner required in the UBO manual?

(9) According to the UBO manual, is all billing current? This includes preparing and sending inpatient claims to the third party payer within 10 business days following completion of the medical record and preparing and sending outpatient claims within 7 days after the outpatient encounter information is obtained? Are all claims for which payment is delinquent (reimbursement not received after 30 days) entered into a suspense file to be called on and monitored?

(10) Are clear and complete audit trails maintained on all claims and forwarded to the appropriate RJA office for pursuit of invalid denials and medical affirmative claims?

d. Supersession. There was no previous checklist.

e. Comments. Comments regarding this checklist should be addressed to the Commander, USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Suite 10, Fort Sam Houston, TX 78234-6010.

C-2. Medical Affirmative Claims Program, also known as the Federal Medical Care Recovery Act

a. Purpose. The purpose of this checklist is to assist Army MTFs in evaluating the key management controls listed below. It is not intended to cover all controls.

b. Instructions. Answers must be based on the actual testing of key management controls (for example, document analysis, direct observation, sampling, simulation, other). Answers which indicate deficiencies must be explained and corrective action indicated in supporting documentation. These management controls must be evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11-2-R.

c. Test questions.

(1) Is there a system in place to identify and report to the appropriate RJA the following: (1) inpatient treatment, (2) outpatient treatment, (3) supplemental care payments or other payments for care provided by a civilian source, and/or (4) ancillary services ordered by an external provider that are associated with an accident/trauma related injury or illness (including AD beneficiaries) for pursuing potential or ongoing medical affirmative claims?

(2) Are procedures in place to ensure the appropriate RJA is notified of information in (a) above, using a variety of sources including, but not limited to the following: the DD Form 2569, a list of admissions or copy of the admissions records, applicable ADS forms, and/or copies of clinic logs?

(3) Is there a procedure in place to identify and report health care services for a non-Federal employment related injury or illness (commonly referred to as worker's compensation) to the appropriate RJA?

(4) Are procedures in place to identify patients with concurrent TPCP and medical affirmative claims, and to notify the appropriate RJA, in a timely manner, that a TPCP health insurance payment or denial is received on a concurrent medical affirmative claim?

(5) Does the MTF receive a monthly report from the appropriate RJA listing medical affirmative claims closed without recovery and claims transferred to another RJA jurisdiction?

(6) Does the MTF receive and maintain a monthly report listing the patient's name, sponsor's SSN, and amount(s) deposited to the MTFs account by the RJA, or a copy of deposit voucher(s) reflecting deposits to the MTFs account by the RJA?

(7) Are procedures in place to ensure medical affirmative claims forms are accurately completed by the MTF and provided to the RJA, with copies of pertinent medical records, in a timely manner?

(8) Does the MTF maintain documentation supporting medical affirmative claims, including, but not limited to UB92s, encounter forms, and DD Forms 2569 after treatment or discharge as addressed in DOD 6010.15-M regarding internal controls?

(9) Are procedures in place to ensure all requests for attorneys, insurance companies, and patients are screened for potential or ongoing medical affirmative claims and these requests are forwarded to the RJA for release or approval for release?

(10) Are procedures in place to ensure separation of duties, that is, that MTF personnel performing medical affirmative claims related billing functions are not also performing medical related claims related collection/deposit functions as addressed in DOD 6010.15-M regarding internal controls?

d. Supersession. There was no previous checklist.

e. Comments. Comments regarding this checklist should be addressed to the Commander, USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Suite 10, Fort Sam Houston, TX 78234-6010.

C-3. Medical services account

a. Purpose. The purpose of this checklist is to assist Army MTFs in evaluating the key management controls listed below. It is not intended to cover all controls.

b. Instructions. Answers must be based on the actual testing of key management controls (for example, document analysis, direct observation, sampling, simulation, other). Answers which indicate deficiencies must be explained and corrective action indicated in supporting documentation. These management controls must be evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11-2-R.

c. Test questions.

(1) Are rates charged eligible beneficiaries for medical, dental, and veterinary care in Army MTFs current?

(2) Is the MSAO appointed by written order of the MTF commander?

(3) Are deputy MSAO/assistant MSAOs, if required, appointed in writing by the MTF commander? Are current procedures established for transfer of MSA accountability?

(4) Is the MSAO not accountable for another appropriated fund or other Government property?

(5) Are current SOPs established for daily operation of the MSA office?

(6) Has the MSAO designated separate accounting technicians and cashiers?

(7) Is the organizational arrangement (separation of duties of accounting technician, cashier, etc.) adequate to protect cash receipts?

(8) Is there a separate drawer or box with a separate key for each cashier, if more than one cashier?

(9) Is the automated CHCS being used to manage accounts receivable? Is CHCS being used to maintain the invoice and receipt (DA Form 3154) control listing? Are invoices and receipts being printed from CHCS as necessary?

(10) Are there procedures to ensure that MTF activities notify the MSAO when chargeable items are provided to the patient and the rate to be charged?

(11) Is the original CHCS-printed copy of the invoice and receipt presented to the patient or sponsor?

(12) Are DD Forms 7 and 7A prepared monthly?

(13) Are charges for subsistence furnished to enlisted personnel inpatients billed to the Military Personnel Army appropriation on an SF 1080?

(14) Are outpatient charges collected in advance of treatment except in case of an emergency?

(15) When outpatient charges are not collected in advance, does the MSAO approve extension of payment period?

(16) Are procedures established to collect on a cash basis at the time veterinary service is provided?

(17) Is DA Form 3154 prepared, receipted, and annotated for veterinary care?

(18) Does the MSAO report delinquent medical bills to the MTF commander for review, as required by AR 37-103?

(19) Does the MSAO have established followup procedures for collecting delinquent accounts, and are all required collection efforts completed within the proper time limits before transferring accounts to FAO?

(20) Does the MSAO coordinate with the chief, food service division to ensure proper security procedures and controls are set up to safeguard the cash fund and money collected by dining facility cashiers?

(21) When a cash register is used in the dining facility, is the person authorized to clear the cash register designated in writing?

(22) Are adequate security containers available to safeguard MSA funds documents?

(23) Are MSA cash collections deposited with the servicing bank weekly or when the fund reaches a total of \$500?

(24) Is cashing checks in excess of the person's debt prohibited?

(25) Are accounting procedures for inpatient/outpatient services established?

(26) Are current procedures established to ensure collections are distributed to the appropriate account?

(27) Are current procedures provided in negotiating prices with civilian providers and health care services?

d. Supersession. There was no previous checklist.

e. Comments. Comments regarding this checklist should be addressed to the Commander, USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Suite 10, Fort Sam Houston, TX 78234-6010.

C-4. Care from civilian sources, Army personnel

a. Purpose. The purpose of this checklist is to assist Army MTFs in evaluating the key management controls listed below. It is not intended to cover all controls.

b. Instructions. Answers must be based on the actual testing of key management controls (for example, document analysis, direct observation, sampling, simulation, other). Answers which indicate deficiencies must be explained and corrective action indicated in supporting documentation. These management controls must be evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11-2-R.

c. Test questions.

(1) Are billings for medical/dental care in excess of \$500 supported by authorization of the approving authority?

(2) Is an eligibility check performed on all claims submitted for payment? (DEERS for AD personnel and orders for RC personnel.)

(3) Is the 30 day standard for processing claims included in an SOP.

(4) Are all claims for inpatient services priced for DRG payment?

(5) Are all claims for ambulatory services priced for CHAMPUS CMAC prior to payment?

d. Supersession. There was no previous checklist.

e. Comments. Comments regarding this checklist should be addressed to the Commander, USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Suite 10, Fort Sam Houston, TX 78234-6010.

C-5. Patient eligibility for care in Army treatment facilities

a. Purpose. The purpose of this checklist is to assist Army MTFs in evaluating the key management controls listed below. It is not intended to cover all controls.

b. Instructions. Answers must be based on the actual testing of key management controls (for example, document analysis, direct observation, sampling, simulation, other). Answers which indicate deficiencies must be explained and corrective action indicated in supporting documentation. These management controls must be evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11-2-R.

c. Test questions.

(1) Are all patients seeking medical care checked for eligibility status, and are procedures outlined in an SOP?

(2) Are foreign nationals provided care per chapter 3 of this regulation?

(3) Are beneficiaries of other Federal agencies provided care per chapter 3 of this regulation?

(4) Are patients who do not appear in the DEERS data base provided care as "civilian emergencies" or "Designee of the Secretary of the Army"?

d. Supersession. There was no previous checklist.

e. Comments. Comments regarding this checklist should be addressed to the Commander, USAMEDCOM, ATTN: MCHO-CL-P, 2050 Worth Road, Suite 10, Fort Sam Houston, TX 78234-6010.

Glossary

Section I Abbreviations

AAD

admission and disposition

ABCA

American, British, Canadian, and Australian

AD

active duty

ADM

active duty member

ADAPCP

Alcohol and Drug Abuse Prevention and Control Program

ADS

Ambulatory Data System

ADT

active duty for training

AMEDD

Army Medical Department

APO

Army Post Office

ARPERCEN

U.S. Army Reserve Personnel Center

ATAC

Army Travelers Assistance Center

AWOL

absent without leave

BAMC

Brooke Army Medical Center

BUMED

Bureau of Medicine and Surgery

CAC

casualty area command

CAP

civil air patrol

CFR

Code of Federal Regulations

CHAMPUS

Civilian Health and Medical Program of the Uniformed Services

CHCS

Composite Health Care System

CMAC

CHAMPUS maximum allowable charge

CONUS

continental United States

CPT4

current procedural terminology (4th edition)

CRO

carded for record only

CSD

Customer Service Division

DA

Department of the Army

DAO

Defense Account Office

DCCS

Deputy Commander for Clinical Services

DCSPER

Deputy Chief of Staff for Personnel

DEERS

Defense Enrollment Eligibility Reporting System

DFAS

Defense Finance and Accounting Service

DOA

dead on arrival

DOD

Department of Defense

DODI

Department of Defense Instruction

DRG

diagnosis related group

EC/PTS

Enabling Care/Patient Tracking System

EIN

employee identification number

EMT

emergency medical technician

EPSBD

entrance physical standards board

EPTS

existed prior to service

FAA

Federal Aviation Administration

FAO

finance and accounting office

FMS

foreign military sales

FN

file number

FY

fiscal year

GAR

geographic area of responsibility

GME

graduate medical education

GPMRC

Global Patient Movement Requirements Center

HCFA

Health Care Financing Administration

HMO

health maintenance organization

HQDA

Headquarters, Department of Army

HREC

health record

ICD-9-CM

International Classification of Diseases (ICD)-Ninth Revision-Clinical Modification

ID

identification (when used as an adjective)

IDT

inactive duty training

IMET

international military education training

IPDS

Individual Patient Data System

ITO

invitational travel order

ITR

inpatient treatment record

ITRCS

inpatient treatment record cover sheet

JFTR

Joint Federal Travel Regulation

LD

line of duty

MACOM

major Army command

MASCAL

mass casualty

MC

Medical Corps

MCS

managed care support

MEB

medical evaluation board

MEDCEN

U.S. Army Medical Center

MEDDAC

U.S. Army medical department activity

Medicare

Social Security Health Insurance Program for the Aged

MEPS

military entrance processing station

MHU

medical holding unit

MMRB

military occupational specialty/medical retention board

MPRJ

military personnel records jacket

MRI

magnetic resonance imaging

MSA

medical services account

MSAO

medical services accountable officer

MTF

military treatment facility

NAD

nonactive duty

NATO

North Atlantic Treaty Organization

NCR

National Capital Region

NG

National Guard

NGR

National Guard regulation

NLD

not in line of duty

NMA

nonmedical attendant

NOAA

National Oceanic and Atmospheric Administration

NOK

next of kin

OASD(HA)

Office of the Assistant Secretary of Defense (Health Affairs)

OB/GYN

obstetrics/gynecology

OCONUS

outside the continental United States

OSJA

Office of the Staff Judge Advocate

OTSG

Office of The Surgeon General

OWCP

Office of Workers' Compensation Programs

PAD

patient administration division

PARRTS

Patient Accounting and Reporting Realtime Tracking System

PASBA

Patient Administration Systems and Biostatistics Activity

PCM

primary care manager

PCS

permanent change of station

PEB

physical evaluation board

PEBLO

physical evaluation board liaison officer

PERSCOM

U.S. Total Army Personnel Command

PHS

Public Health Service

POE

port of embarkation

POR

preparation of replacements for overseas movement

PTF

patients' trust fund

QSTAG

Quadripartite Standardization Agreement

RC

Reserve Component

RCS

report control symbol

REP 63

Reserve Enlistment Program of 1963

RJA

recovery judge advocate

RMC

regional medical commands

ROTC

Reserve Officers' Training Corps

SCI

spinal cord injury

SHCP

Supplemental Health Care Program

SI

seriously ill

SIDR

Standard Inpatient Data Record

SJA

staff judge advocate

SOFA

Status of Forces Agreement

SOLOG

Standardization of Certain Aspects of Operations and Logistics

SOP

standing operating procedure

SPECAT

special category

SROTC

Senior Reserve Officers' Training Corps

SS

selective service

SSA

Social Security Administration

SSN

social security number

STANAG

standardization agreement

STS

specialized treatment service

TAMC

Tripler Army Medical Center

TAMMIS

Theater Army Medical Management Information System

TDRL

temporary disability retired list

TDY

temporary duty

TM

technical manual

TOE

table of organization and equipment

TPCP

Third Party Collection Program

TPRP

TRICARE Prime Remote Program

TSG

The Surgeon General

UB

uniform bill

UBO

Uniform Business Office

UCMJ

Uniform Code of Military Justice

USAMEDCOM

United States Army Medical Command

USAR

U.S. Army Reserve

USAREUR

U.S. Army, Europe

USC

United States Code

USCG

U.S. Coast Guard

USFHP

Uniformed Services Family Health Plan

USO

United Service Organization

USSAH

U.S. Soldiers' and Airmens' Home

VA

Department of Veterans Affairs

VARO

VA Regional Office

VASRD

Veterans' Administration Schedule for Rating Disabilities

VISTA

Volunteers in Service to America

VSI

very seriously ill

WWR

worldwide workload reporting

Section II**Terms****Absent sick**

An AD (Army, Navy, Air Force, Marine Corps) member hospitalized in other than a U.S. MTF and for whom administrative responsibility has been assigned to a U.S. MTF.

- a. *Absent sick moved to MTF.* Patients who have been moved from a non-U.S. military facility to an MTF.
- b. *Total absent sick.* Patients who are absent sick the total time (never moved to an MTF).

Active Army*a. Consists of—*

- (1) Regular Army soldiers on AD;
- (2) Army NG of the U.S. and Army Reserve soldiers on AD except as excluded in b below;
- (3) Army NG soldiers in the service of the U.S. pursuant to a call; and
- (4) All persons appointed, enlisted, or inducted into the Army without component.

b. Excluded are—

- (1) Soldiers serving on ADT;
- (2) Active Guard and Reserve status;
- (3) Active duty for special work;
- (4) Temporary tours of AD for 180 days or less; and
- (5) AD pursuant to the call of the President (10 USC 673b).

Active duty

Full-time duty in the active military service of the United States. It includes Federal duty on the active list (for NG personnel), full-time training duty, AT, and attendance, while in the active military service, at a school designated as a service school by law or the Secretary of the military department concerned.

Active practice (dental)

Engagement by a dentist in the clinical practice of dentistry for more than 30 hours per week.

Adjunctive dental care

That care necessary to improve systemic medical conditions. Such care would be provided upon the certification of the attending physician and dentist that the indicated dental treatment would be an integral part of the treatment of the diagnosed medical or surgical disease or condition and is essential to the control of the primary condition.

Bed day

a. Bassinet day. A day in which a live birth at the reporting facility occupied a bassinet in the newborn nursery at the census taking hour (normally midnight). The stay must be continuous since birth. The stay is also not dependent on the status of the mother. This excludes days spent by infants in a bassinet on a pediatric nursing unit, pediatric or neonatal intensive care unit, or other nursing unit.

b. Bed day.

(1) A day in which a patient occupied an operating bed at the census taking hour (normally midnight). The following are also counted as bed days:

(a) A patient admitted and discharged on the same day. This excludes ambulatory surgery procedures performed in a clinic.

(b) Same day transfer out if a patient is transferred to a nonmilitary treatment facility.

(2) When the patient occupies a bed day in more than one inpatient care area in 1 day, the bed day shall be counted only in the inpatient care area where the patient is located at the census-taking hour.

(3) This definition excludes days during which the inpatient is subsisting out, on convalescent leave, on authorized or unauthorized leave, or in a transient status. AD military patients not requiring inpatient care, and assigned for administrative or other nonmedical reasons, shall not be counted as a bed day.

Beneficiary

Defined for purposes of 10 USC 1095, the Third Party Collection Program, any person determined to be eligible for benefits and authorized treatment in an MTF, covered by 10 USC 1074(b), 1076(a) or 1076(b). These are retirees, family members of retirees, and family members of AD; for purposes of automobile insurance, authority extends to AD members of the Uniformed Services.

Carded for record only

Special cases not admitted to an inpatient status but require the preparation of a DA Form 3647 or a DD Form 1380 (US Field Medical Card) and the assignment of a register number.

CHAMPUS maximum allowable charge

The maximum payment reimbursable by CHAMPUS for a specific medical/clinical treatment or procedure.

Civilian agency

Physicians, hospitals, clinics, special nurses, dentists, pharmacists, veterinarians, practitioners in allied sciences, blood donors, ambulance companies, and makers of prosthetic devices.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

The “insurance plan” instituted by Congress for cost sharing with eligible beneficiaries in obtaining covered health care benefits from the civilian community when those health care needs cannot be met by a uniformed MTF.

Continental United States

The 48 contiguous States and the District of Columbia.

Convalescent leave

In this regulation, an authorized leave status considered a sick day when the convalescent leave occurs before the disposition of the patient. It is granted to AD members while under medical or dental care and prescribed for their recuperation or convalescence. Convalescent leave under this regulation is not the same as convalescent leave occurring after disposition of the patient or while the patient is en route to a new command. It is also not the same as convalescent leave granted by a line commander after patient discharge from the hospital.

Custodial care

Care rendered to mentally or physically disabled patients who require a protected, monitored, or controlled environment as opposed to active and specific medical, surgical, or psychiatric treatment.

Deductible

An annual amount that a patient must pay out-of-pocket for care before CHAMPUS begins to share costs.

Direct admission

Admission to the reporting MTF for the current, uninterrupted period of hospitalization.

Disability separation

Temporary or permanent retirement and discharge for physical disability, with or without entitlement to receive severance pay.

Disposition

The discharge of a patient from a MEDCEN or hospital, that is, a discharge to duty or home, transfer to another MTF, death, or other termination of inpatient care.

Domiciliary care

Inpatient institutional care provided the beneficiary not because it is medically necessary, but because the care in the home setting is not available, is unsuitable, or members of the patient’s family are unwilling to provide the care. Institutionalization because of abandonment constitutes domiciliary care.

Note. Domiciliary care and custodial care represent separate concepts and are not interchangeable.

Elective care

Nonemergency care that, in the opinion of the cognizant medical authority, is not medically required but is requested or preferred by the patient. Examples are: face lift, vasectomy, and augmentation mammoplasty.

Emergency care

a. Medical treatment of patients with severe life-threatening or potentially disabling conditions resulting from accident or illness of sudden onset. These conditions necessitate immediate care to prevent undue suffering or loss of life.

b. Dental treatment for relief of painful or acute conditions.

Existed prior to service

A term added to a medical diagnosis to signify there is clear and unmistakable evidence that the disease or injury or the underlying condition producing the disease or injury existed prior to the individual’s entry into military Service.

Family members

a. Family members of members of the Uniformed Services. Family members include persons who are related ((1) through (5) below) to an AD soldier who is serving under a call or order that does not specify a duty period of 30 days or less. Persons are also family members if the soldier died while serving on such AD, is retired, or died while in a retired status. This includes family members of retired members of RC if the member died while under 60 years of age and chose to take part in the Survivor Benefit Plan. In such a case, the family member’s entitlement becomes effective

on the date the deceased retiree would have been 60 years of age. Categories of family members and their specific entitlements are as follows:

- (1) Spouse, even if not actually dependent on the AD or retired member.
- (2) The unremarried former spouse of an active or retired member whose marriage to the member was dissolved on or after 1 February 1983 who—
 - (a) On the date of marriage dissolution had been married to the member for at least 20 years during which time the member performed at least 20 years of service that is creditable in determining eligibility for retired or retainer pay.
 - (b) Does not have medical coverage under an employer-sponsored health plan.
- (3) Unremarried widow or widower even if not actually dependent on the AD or retired member at the time of the member's death.
- (4) A legitimate child, an illegitimate child who has been legitimized or whose paternity has been judicially determined, an adopted child who is adopted before age 21, or stepchild, who is unmarried and is—
 - (a) Under 21 years of age even if not dependent on the AD or retired member.
 - (b) Twenty-one years of age or older but incapable of self-support because of a mental or physical disorder that existed before his or her 21st birthday and is, or was at the time of death of the AD or retired member, dependent on the member for over one-half of his or her support.
 - (c) Twenty-one or twenty-two years of age and pursuing a full-time course of education. The course must be approved by the Secretary of Defense or the Secretary of Education, as applicable, or by a State agency under 38 USC 1775. Further, the person must be, or must have been at the time of death of the AD or retired member, dependent for over one-half of his or her support. A child in this category, who during the school year or between semesters suffers a disabling illness or injury that interrupts attendance at the institution, remains eligible for care until 6 months after the disability is removed or until his or her 23rd birthday, whichever occurs earlier.

Note. A child includes an unmarried child of a male member who was illegitimate at the time of birth and who is, or was at the time of death of the AD or retired member, dependent on the member for more than one-half of his or her support. The child must also reside with or in a home provided by the member or the parent who is the member's spouse. A child also includes the illegitimate child of an AD or retired female member. Children in this category are eligible for medical care on the date of birth since they need not be dependent on the female member for support or reside in a home provided by the member.

(5) Parent or parent-in-law (natural or adoptive) who is, or was at the time of death of the AD or retired member, dependent on the member for over one-half of his or her support and residing in a dwelling place provided or maintained by the member. (This does not include a stepparent or person who has assumed the role of a parent.)

b. Family members of foreign nationals. Eligible spouses and children only. (The same conditions apply as for U.S. family members.)

Federal medical treatment facilities

Includes Department of Veterans Affairs treatment facilities.

Final disposition

When an inpatient is no longer carried on the rolls of a U.S. armed forces MEDCEN or MEDDAC. The reason is discharge to duty or home, death, separation, retirement, or other termination of inpatient status. The inpatient receives final disposition when the MEDCEN or hospital formally terminates the period of inpatient hospitalization.

Fixed military treatment facility

A military treatment facility designed to operate for an extended period of time at a specific site.

Full reimbursable rate

The full cost to the Government of providing medical care to a noneligible patient.

Funds

Domestic currency and coins, cashier's checks, travelers's checks, checks drawn on the Treasurer of the United States, and checks drawn on another PTF, when accepted for deposit.

Health care finder

A person who makes test and specialty care appointments for patients in the MTF or contractor network.

Health maintenance organization

A prepaid plan (like TRICARE Prime) that uses a limited, select network of health care providers/practitioners. HMOs usually cover a full range of services and often emphasize preventive and primary care rather than high cost specialty care.

Health record

The OTR and the dental record of a military member.

Individual Patient Data System

A computer-oriented collection of selected demographic and medical data. The data apply to inpatients treated by the AMEDD and cases of sufficient interest as to require reporting as CRO. The IPDS also includes data on AD personnel who are absent sick in civilian hospitals.

Inpatient rate

A flat, per diem, hospitalization charge determined by DOD. No credit is given for meals not consumed.

Inpatient treatment record

The record used at an MTF that has authorized beds for inpatient medical or dental care. It is begun on admission to the MTF and completed at the end of hospitalization. This record applies to all beneficiaries.

Intermediate individual

An individual with each professional department or service who is charged with specific responsibility for all transactions between patients who have established an account with the PTF and the custodian of the PTF that require the services of an intermediate recipient.

Major overseas commanders

The Commander-in-Chief, U.S. Army, Europe and Seventh Army; Commanding General, U.S. Army, Japan; Commanding General, Eighth U.S. Army; and Commanding General, U.S. Army, Western Command.

Managed care

Any health care plan that initiates selective contracts or payments between providers/practitioners, employers, and/or insurers to channel patients to a specific set of cost-effective, quality health care providers/practitioners.

Maternity care

Prenatal care, hospitalization, delivery, and 6 weeks of postnatal follow-up care relating to the current pregnancy.

Maximum hospital benefit

That point of hospitalization at which the patient's progress appears to have stabilized and further hospitalization will not directly contribute to further substantial recovery. A patient who will continue to improve slowly over a long period of time without specific therapy or medical supervision or with only a moderate amount of treatment on an outpatient basis may be considered as having attained maximum hospital benefit.

Medical care

Unless otherwise specified, includes, but is not limited to the following:

- a. Inpatient treatment.
- b. Outpatient treatment.
- c. Nursing care.
- d. Medical examinations.
- e. Immunizations.
- f. Drugs.
- g. Subsistence.
- h. Transportation.
- i. Other adjuncts such as prosthetic devices, spectacles, hearing aids, and orthopedic footwear. This includes appliances such as braces, walking irons, and elastic stockings.

Medical management

The exercise of primary decision authority regarding diagnosis and treatment of an individual patient.

Medical officers

Commissioned officers of the armed forces or civilians who are either employees, consultants, or fee-for-service physicians.

Member of a Uniformed Service

A person appointed, enlisted, inducted, or called, ordered, or conscripted into a Uniformed Service who is serving on AD or ADT.

Military patient

A patient who is a member of the U.S. Armed Forces on AD or ADT or an AD member of the armed forces of a foreign government.

Military treatment facility

A facility established for the purpose of furnishing medical and/or dental care to eligible beneficiaries.

Optimum hospital benefit

The point during hospitalization when a patient's fitness for further military service can be decided. Also, further treatment for a reasonable period in an MTF will probably not result in material change in the patient's condition so as to alter type of disposition or amount of separation benefits.

Outpatient

A person receiving health service for a disease or injury that does not require admission to an MTF for inpatient care.

Outpatient treatment record

The OTR and the dental record of the beneficiary for whom an HREC is not kept.

Outpatient visit

A visit to a separate, organized clinic or specialty service. This visit is made by a patient who has not been admitted as an inpatient to the supporting hospital.

Outside of the United States

All areas outside of the 50 States and the District of Columbia.

Patient Accounting and Reporting Realtime Tracking System

An automated system that collects demographic and medical data of patients entering the medical system during a contingency operation. The patient is tracked through the entire episode of care until final disposition.

Point-of-service option

The freedom to obtain services from civilian providers on a case-by-case basis. Such freedom is retained by TRICARE Prime enrollees. In such cases, all requirements applicable to standard CHAMPUS apply, except that there are higher deductible and cost sharing requirements. Under Prime, for care not authorized by the PCM or health care finder, deductibles and cost sharing requirements apply.

Practical military training

Any training activity which is part of the Army ROTC education and training program. Practical military training also includes the Advanced Training Program, Field Training, and other ROTC-sponsored and supervised activities which enhance the program by focusing on specific training goals and objectives and prepare the cadet for service as an Army officer. The Army ROTC will not sponsor potentially hazardous activities. Examples of these activities include but are not limited to rappelling, hang gliding, parasailing, parachute jumping, paint ball wars, and other activities where substantial liability is possible. Legitimate intramural or similar activities are permissible.

Primary care manager

The first echelon provider that exercises primary decision authority regarding diagnosis and treatment of an individual patient. The primary care manager may be an individual physician, or group practice within a specific clinic or treatment site, or other designation. The primary care manager may be part of the MTF or the Prime civilian provider/practitioner network. The enrollees will be given the opportunity to register a preference for primary care manager from a list of choices provided by the MTF commander. Preference requests will be honored subject to availability under the MTF beneficiary category priority system and other operational requirements established by the commander (or other authorized person).

Quarters

Disposition of a military patient when the patient is returned to his or her unit or home for medically directed self-treatment and is not to perform military duty until a medical officer indicates that he or she may perform such duties.

Responsible individual

An individual who is responsible for transactions relative to deposits in the patients' trust fund when the patient is unable to deposit directly with the custodian or assistant custodian.

Retired member

A member or former member of a Uniformed Service who is entitled to retired or retainer pay, or equivalent pay, as a result of service.

Routine care

a. Routine dental care. All dental care necessary to maintain dental health and function other than care of an emergency or elective nature.

b. Routine medical care. Nonemergency care that is required and medically indicated.

Subsistence rate charges

A flat, per diem, hospitalization charge which applies to enlisted and officers. No credit is given for meals not consumed.

Subsisting out

The nonleave status of an inpatient who is no longer assigned to an operating bed and whose days become sick days, not occupied bed days. Inpatients authorized to subsist out are not medically able to return to duty, but their continuing treatment does not require a bed assignment.

Supplemental care

Funds used to obtain civilian health care for eligible beneficiaries when that care is not available in the MTF.

Transfer

Occurs each time an inpatient is transported from one MTF (civilian or military) to another MTF.

TRICARE Extra option

The health care option, provided as part of the TRICARE program under Section 199.17. Under this option, beneficiaries may choose to receive care in facilities of the Uniformed Services on a space-available basis, or when CHAMPUS eligible beneficiaries use the preferred providers in the TRICARE contractor's network at a beneficial discount, and (usually) no claim forms have to be filed by the patient. When CHAMPUS non-network providers are used, the standard CHAMPUS cost shares apply. This option does not require TRICARE enrollment, but the beneficiary must be registered in DEERS.

TRICARE managed care support contract

A contract providing personnel and other resources to an MTF in order to increase the availability of services.

TRICARE Prime option

The health care option provided as part of the TRICARE program under Section 199.17. Under this option, beneficiaries enroll to receive all health care from facilities of the Uniformed Services and/or civilian network providers/practitioners through primary care managers and health care finders resulting in substantial cost savings.

TRICARE Program

A regionally managed care HMO type program for members of the Uniformed Services and their families, retired members and their families, and survivors. TRICARE brings together the health care delivery systems of each of the military services in a cooperative and supportive effort to better serve DOD beneficiaries and use the resources available to military medicine. Through the help of the TRICARE managed care support contracts, civilian provider networks are created along with other managed care support services to develop, implement, and operate a comprehensive managed health care delivery system for military health system beneficiaries.

TRICARE Standard option

The health care option, provided as part of the TRICARE program under Section 199.17. Under this option, beneficiaries are eligible for care in facilities of the Uniformed Services and CHAMPUS under standard rules and procedures.

Uncharacterized service

Entry level status separation characterized as honorable or general (under honorable conditions) except as noted in AR 635-200, paragraph 3-9.

Uniformed Services

The Army, Navy, Marine Corps, Air Force, Coast Guard, Commissioned Corps of the Public Health Service, and the Commissioned Corps of the National Oceanic and Atmospheric Administration.

Section III**Special Abbreviations and Terms**

This section contains no entries.

Index

This index is organized alphabetically by topic and subtopic within a topic. Topics and subtopics are identified by paragraph number.

Abbreviations and terms, glossary

Abortions, 2–18, 6–4

Aeromedical transportation, 2–18

Moral or religious objections, 2–18

Abortion Statistics Report (RCS MED–363), 15–4

Absent sick, 4–6, 8–3, 10–11, 13–4, glossary

Acupuncture, 10–2

Admission and disposition, 3–19, 4–6, 9–9

Aeromedical evacuation/transportation, 2–18, 3–62, 5–18, 7–14

Alaska natives, 3–25, appendix B

Alcohol, 3–15, 5–18, 14–7

Ambulance, 10–2, 13–1

Ambulatory Data System, 15–9

American nationals, 3–49, appendix B

American Samoan citizens, 3–36, appendix B

Ancillary medical services, 2–16

Army Central Registry, 15–10

Attorney, 2–12, 3–30, 5–14, 13–5, 14–12

Autopsy authority and consent, 6–5

Bed day, 4–1, 5–7, glossary

Brain injury patients, 5–18, 8–4

Brooke Army Medical Center, 7–4

Canadian military personnel, 3–19

Carded for record only, 4–6, 6–3, glossary

Care beyond an MTFs capability, 2–14

Catchment area, 2–8, glossary

Certain personnel evacuated from one area to another, 3–54

CHAMPUS maximum allowable charge, 10–9

Christian Science services, 10–2

Civil Air Patrol, 3–24

Civilian employees. See in Army MTFs and care authorized

Civilian sources

Abortions and sterilization, 2–18

Ancillary services, 2–16

Apprehended members, 10–4

Approving authorities, 10–5

Authorization for, 10–6

Autopsies, 10–8

AWOL members, 10–3

Dental care, 10–7

Maternity care, 2–8, 3–39

Medical records and reports, 10–11

Newborn infants, 3–39

Payment of civilian medical claims, 10–10

Personnel authorized care, 10–1

Qualifications of personnel furnishing medical care, 10–2

Rates of compensation, 10–9

Supplemental care, table 2–1, table 2–2, table 2–3

Comfort items for patients, 4–3

Commercial transportation or travel, 2–6, 9–9

Consent by nonmilitary patient, 2–12

Contraception, 2–17

Convalescent leave, 5–1, glossary

Cosmetic surgery, 2–19

Custodial care, 2–15, glossary

Customer Service Division/Patient Administration and Biostatistics Activities

Abortion Statistics Report (RCS MED–363), 15–4

Ambulatory Data System, 15–9

Army Central Registry, 15–10

Authority, 15–1

Data system studies, 15–3

Diagnostic and operative indices, 15–5

Enabling Care/Patient Tracking System, 15–7

Patient administration contingency operations, 15–8

Standard Inpatient Data Record, 15–2

Workload report, 15–6

Deceased persons, 3–11, 4–7, 6–1, 6–4, 9–3, glossary

DEERS, 2–1, 2–2, 3–50, 4–2

Dental care

Application of charges, 11–14

Care not authorized, 3–12

Civilian student employees, 3–43

Commander as final authority, 2–3

Cost of commercial or privately owned transportation, 2–6

Cosmetic, 2–19

Department of State and associated agencies, 3–27

Facilities other than those of the Uniformed Services, 9–4

Family members, 3–11, 3–12, 3–52

Final disposition procedures, 5–17

Foreign nationals, 3–18

Health care services include, 13–1

Job Corps, 3–33

Line of duty, 3–3

Non–AD chaplains, 3–50

OWCP, 3–24, 3–41

Prosthesis, 3–3

Public Health Service and NOAA, 3–25

Request for dental records, 5–19

Reserve Components, 3–2

Retired members, 3–9

Routine, 3–3, 10–7, glossary

Seamen, 3–41

Senior Reserve Officers' Training Corps, 3–3

Workload report exemption, 15–6

Department of Justice beneficiaries, 3–30, appendix B

Department of State beneficiaries, 3–27, appendix B

Department of Treasury beneficiaries, 3–31, appendix B

Designees of the Secretary of the Army, 2–2, 3–12, 3–29, 2–38, 3–50, 3–51, 3–52, 3–54, 3–62, 3–63, 3–64, appendix B

Detoxification, 3–15

Direct admission, 13–3, glossary

Disability separation, 7–3, 7–9, 8–14, glossary

Discharge, expeditious, 7–5, 7–11

Dispositioning patients

Assigned patients in CONUS, 8–7

Change of duty or station, 5–4

Claims files, 14–12

Continued hospitalization or nursing home care, 5–18

- Domiciliary care, 5–11
- Evacuation of military spouses from overseas areas to the U.S., 5–24
- Final procedures for military patients, 5–17
- Foreign military patients, 5–21
- General policies, 5–1
- Length of hospitalization, 5–6
- Members of temporary disability retired list, 5–8
- Nonmilitary patients mentally ill in a foreign country, 5–23
- Notification of release of criminal Army members, 5–16
- Overseas MTFs, 8–10
- Patients of NATO nations, 5–20
- Prisoner patients, 5–13, 5–15
- Psychiatric patients, 5–14, 5–15, 5–18, 5–23
- RC and ROTC members, 5–9
- Request for records, 5–19
- Reserve components, 8–12
- Responsibility, 5–2
- Return from overseas to CONUS for medical reasons, 5–5
- Sick call, 5–12
- Types of, 5–3, 5–22
- U.S. Navy and U.S. Air Force patients, 5–10
- Use of subsisting out status, 5–7

Domestic servants, 3–58, appendix B

Domiciliary care, 2–15, 5–11, glossary

Durable medical equipment, 13–1

Drugs

- Authorized family members, 3–11
- Dependent patients, 5–18
- Records release, 14–7
- Refills, 11–14
- TPCP insurance claims, 14–8

Drug Enforcement Administration, 3–27

Elective care, 2–18, 2–19, 3–43, glossary

Eligibility for care in Army MTFs and care authorized

- American Nationals, 3–49
- American Samoan citizens, 3–36
- Applicants for appointment in the Regular Army and Reserve Components, including members of the Reserve Components who apply for active duty, 3–7
- Applicants for cadetship at the Service academies and ROTC scholarship applicants, 3–5
- Applicants for enlistment or reenlistment in the Armed Forces, including applicants for enlistment in the Reserve Components, 3–6
- Applicants who suffer injury or acute illness, 3–8
- Beneficiaries of the Department of Justice, 3–30, appendix B
- Beneficiaries of the Department of State and associated agencies, 3–27, appendix B
- Beneficiaries of the Department of Veterans Affairs, 3–23
- Beneficiaries of the Office of Workers' Compensation Programs, 3–24
- Beneficiaries of the Public Health Service and National Oceanographic and Atmospheric Administration, 3–25
- Beneficiaries of the Treasury Department, 3–31
- Care authorized family members, 3–11
- Care not authorized family members, 3–12
- Certain personnel evacuated from one area to another, 3–54
- Civilian employees of U.S. Government contractors and their family members outside the United States, 3–44
- Civilian faculty members of the Uniformed Services University of Health Sciences, 3–64
- Civilians in a national or foreign disaster, 3–65
- Civilians in emergency, 3–55
- Civilians injured in alleged felonious assaults on Army installations, 3–60

Civilian participants in Army-sponsored activities, 3-46
 Civilian student employees, 3-43
 Claimants whose claims are administered by Federal departments and claimants who are the proposed beneficiaries of private relief bills, 3-47
 Department of Interior civilian employees stationed in American Samoa and their family members, 3-17
 Designated applicants for enrollment in the Senior Reserve Officers' Training Program (except ROTC scholarship applicants), 3-4
 Designees of the Secretary of the Army, 3-50
 Domestic servants outside the United States, 3-58
 Donors and recipients of organ transplants performed in MTFs, 3-63
 Family members of certain members sentenced, discharged, or dismissed from the Uniformed Services, 3-52
 Federal Aviation Administration air traffic control specialists, 3-32
 Federal civilian employees, 3-14
 Federal civilian employees and their family members outside the United States and at remote installations in the United States, 3-16
 Foreign Nationals, care provided in the United States, 3-18
 Foreign Nationals, care provided outside the United States, 3-20
 Foreign Nationals, charges for and extent of care, 3-21
 Foreign Nationals, notification of hospitalization in the United States, 3-19
 General, 3-22
 Individuals whose military records are being considered for correction, 3-40
 Ineligible persons outside the United States, 3-53
 Job Corps and other Congressionally mandated Volunteer Programs in Service to American and applicants, 3-33
 Maternity care for former members of the Armed Forces, 3-39
 Medical examinations for civilian employees of DoD contractors, 3-45
 Members of the Senior Reserve Officers' Training Corps of the Armed Forces, 3-3
 Members of the Uniformed Services on active duty, 3-1
 Members of the Uniformed Services Reserve Components, 3-2
 Members of the U.S. Soldiers' and Airmen's Home, 3-29
 Micronesian citizens, 3-35,
 Occupational health services, 3-15
 Peace Corps personnel (volunteers, volunteer leaders, and employees), including Peace Corps applicants, and family members of volunteer leaders and employees, 3-28
 Persons in military custody and nonmilitary Federal prisoners, 3-38
 Persons who provide direct services to the U.S. Armed Forces outside the United States, 3-48
 Preadoptive children and court appointed wards, 3-51
 Red Cross personnel, 3-42
 Retired members, eligible, 3-9
 Retired members, periodic medical examinations, 3-10
 Returned military prisoners of war and their family members, 3-62
 Seamen, 3-41
 Secret Service protectees and protectors, 3-37
 Selective Service registrants, 3-26
 Social Security beneficiaries, 3-34
 Surviving dependents of Reserve members, 3-13
 Treatment of former military personnel, 3-61,
 Unremarried former spouse, 3-66
 U.S. contractor civilian employees stationed in American Samoa, 3-59
 U.S. nationals in foreign penal institutions, 3-57
 Volunteer subjects in approved Department of the Army research projects, 3-56
Eligibility verification, 2-1
Emergency care, 2-8, 3-18, 3-25, 4-6, 10-6, 13-1, appendix B
Enabling care, 6-3, 15-7
Evacuation, 2-13, 3-15, 3-27, 3-28, 3-50, 3-62, 4-6, 5-5, 5-18, 5-20, 5-23, 5-24, 7-14, 8-4, 9-9, appendix B
Existed prior to service, 2-8, 3-39, 5-3, 7-8, 7-11, table 7-1
Family member

- Accompanied by non-medical attendant, 2-6
- Ancillary medical services, 2-16
- Application of charges, 11-14
- Care authorized, 3-11
- Care not authorized, 3-12
- Care outside the United States, 3-20
- Civilian care in areas other than the U.S., Puerto Rico, Canada, Mexico, and European command, 13-10
- Civilian care in European Command, 13-9
- Civilian care in U.S., Puerto Rico, Canada, Mexico, 13-8
- Civilian care under TRICARE, 10-1
- Claims, 14-8
- Department of Interior civilians stationed in American Samoa, 3-17
- Department of State and associated agencies, 3-27
- Educational representatives, 3-48
- Employees of U.S. Government contractors, 3-44
- Evacuation, 5-23
- Federal civilian employees and, 3-16
- Federal civilian employees and, 3-18
- Former military personnel, 3-61
- ID cards, 2-2
- IMET and FMS military trainees, 3-20, 3-21
- Navy or Air Force charges, 9-2
- Non active duty chaplains, 3-50
- Of certain members sentenced, discharged, or dismissed from the Uniformed Services, 3-52
- Of volunteer leaders, 3-28
- Priority category, 2-3
- Psychiatric, 2-15
- Red Cross, 3-42
- Returned prisoners of war, 3-62
- Social Security beneficiaries, 3-34
- Transfer of, 5-18
- Transportation of, 2-11
- U.S. nationals in foreign penal institutions, 3-57
- VIP patients, 6-3
- Family planning services, 2-17, 2-18**
- Federal Aviation Administration, 3-28, 3-32**
- Final disposition, 5-7, 5-10, 5-17, 5-18, 7-5, 7-8, 15-7, glossary**
- Fixed MTFs, 11-1, 11-2, 15-8, glossary**
- Foreign nationals, 3-18, appendix B**
 - Nonstudent, 3-19
 - Notifications, 6-2
 - Special, 3-20
 - Transplant ineligible, 3-63
- Former military personnel, 3-61, appendix B**
- Full reimbursable rate, 3-3, 3-39, 3-53, 3-55, glossary**
- Geographic area of responsibility, 2-8, 5-18**
- Government property, 4-4, 11-2, 12-5**
- Health care finder, 2-14, glossary**
- Health maintenance organization, 14-8, glossary**
- Health record, 5-5, 7-8, 7-10, 7-11, table 7-1, 9-9, 10-7, 10-11**
- Hearing aids, 3-2, 3-3, 3-12, 3-23, 3-24, appendix B**
- Identification (of patients), 2-1, 2-2, 4-2, 14-5**
- Immunizations, 2-16, 3-3, 3-16, 3-23, 3-25, 3-27, 3-28, 3-33, 3-46, 3-58, 11-15, appendix B**
- Individual patient data system, 4-6, 7-11, 13-3, 15-2, glossary**
- Ineligible patients, 2-2, 3-61**

- For assignment to MHU, 8–4
- Outside the United States, 3–53, appendix B
- Inpatient rate, 11–14, 13–6, glossary**
- Inpatient treatment record, 4–6, 5–5, 5–15, 5–18, 5–23, 9–9, 10–11, glossary**
- Inpatient treatment record cover sheet, 15–4**
- Intermediate individual, 12–5, glossary**
- International military education training, 3–18, 3–20, 3–21, appendix B**
- International students, 3–18, 3–19**
- Job Corps, 3–24, 3–33, appendix B**
- Line of duty, 2–3, 2–9, 2–14, 3–2, 3–3, 3–4, 3–24, 3–27, 5–9, 7–21, 7–24, 9–9, appendix B**
- Line of duty–not, 3–2, 3–3, 5–18**
- Major overseas commanders, 1–4, 3–16, 3–20, 3–53, 5–9, 5–10, 5–23, 8–10, 10–2, glossary**
- Management and accountability of hospitalized patients**
 - Comfort items for patients, 4–3
 - Government property, 4–4
 - NATO STANAG 2132 and ABCA QSTAG 470 and international agreement requirements, 4–7
 - and admission processes, 4–6
 - Patient control, 4–1
 - Patient identification, 4–2
 - Personal effects, 4–5
- Maternity care for active duty members**
 - Discharged female members, 2–2
 - For former members of the Armed Forces, 3–39
 - Physical limitations of pregnant soldiers, 2–8
 - While in a leave status, 2–8
- Maximum hospital benefit, 5–6, 5–9, glossary**
- Medical affirmative claims injury and illness cases**
 - Absent sick active duty personnel, 13–4
 - Care in medical treatment facilities of a foreign government, 13–12
 - Civilian care furnished family members and retirees in areas other than the U.S., Puerto Rico, Canada, Mexico and in the European command, 13–10
 - Civilian care furnished family members and retirees in the European command, 13–9
 - Civilian care furnished family members and retirees in the U.S., Puerto Rico, Canada, and Mexico, 13–8
 - Claims for reimbursement for civilian care, 13–11
 - Claims forms, 13–6
 - Concurrent and TPCP claims, 13–7
 - General, 13–1
 - Interface and support, 13–2
 - Medical records, 13–5
 - Notification procedures, 13–3
- Medical evaluation boards**
 - Appointing authority, 7–2
 - Approving authority, 7–12
 - Composition, 7–3
 - Counseling concerning results, 7–17
 - Distribution of proceedings, 7–13
 - Documentation for referral to a PEB, 7–10
 - Expedition discharge, 7–11
 - General, 7–1
 - Interservice cooperation, 7–14
 - Narrative summaries, 7–24
 - Preparation of DA Form 3947, 7–9
 - Procedures for Medical Corps officers, 7–4
 - Proceedings, 7–7
 - Processing actions related to PEBs, 7–19

- Recording proceedings, 7–8
- Records to PEB, 7–23
- Referral to a PEB officer, 7–22
- Referrals, 7–21
- Sanity boards, 7–6
- Service coordination channels, table 7–2
- Service reviewing authority options, 7–16
- Transmittal to PEB, 7–18
- Triservice coordination, 7–15
- Use of, 7–5
- VA Physician’s Guide for Disability Evaluation Examinations and the VASRD, 7–20
- Medical holding unit, 4–4, 4–6, 5–1, 5–5, 5–7, 5–17, 5–18**
 - Assignment of AD personnel, 8–4
 - Attachment of AD personnel, 8–3
 - Disposition of assigned patients in CONUS, 8–7
 - Disposition of patients in overseas MTFs, 8–10
 - Dispositioning RC personnel, 8–12
 - Duty for assigned patients awaiting orders in CONUS, 8–9
 - General, 8–1
 - Individual records and clothing, 8–5
 - Notification of admission and discharge, 8–2
 - Performance of duty while in patient status, 8–13
 - Prolonged definitive medical care, 8–14
 - Requests for assignment instructions, 8–8
 - Return to duty of attached patients, 8–6
 - Separation of enlisted personnel assigned to, 8–11
- Medical management, 9–2, glossary**
- Medical service accounts, 12–4, 12–6, 13–6, 14–8, 14–10**
 - Application of charges, 11–14
 - Assistant medical services accountable officers, 11–4
 - Audit and review, 11–10
 - Automation, 11–9
 - Billing and reporting procedures, 11–17
 - Change fund, 11–8
 - Chargeable medical examinations and immunizations, 11–15
 - Charges, 11–13
 - Emergency relief of medical services accountable officer, 11–5
 - Internal controls, 11–19
 - Medical services accountable officer appointment, 11–2
 - Medical services accountable officer deputy appointment, 11–3
 - Medical services accountable officer discontinuance statement, 11–7
 - MSA transfer certificate sample, figure 11–1
 - MSAO discontinuance statement, figure 11–2
 - Negotiable instruments, 11–18
 - Physical loss of medical services accounts funds, 11–11
 - Policies, 11–1
 - Reports, 11–12
 - Statement of new custodian, figure 11–4
 - Statement of outgoing custodian, figure 11–3
 - Transfer of medical services accounts accountability, 11–6
 - Use of credit cards for payment, 11–16
- Medical Services Account Users Manual, 4–6, 11–1, 11–13, 12–1**
- Medical services accountable officer, 2–2, 11–1, 11–2, 11–3, 11–4, 11–5, 11–6, 11–7, 11–8, 11–9, figure 11–1, figure 11–2**
- Micronesian citizens, 3–35, appendix B**
- Military records being considered for correction, 3–40, appendix B**

- National capital region, 3–50**
- National Oceanographic and Atmospheric Administration, 3–25, 3–39, appendix B**
- Native Americans, 3–25, appendix B**
- NATO ABCA STANAG agreements, 2–5, 4–7**
- NATO nations, 3–18, 3–20, 3–21, appendix B**
 - Patients of, 5–20
- Newborns, 2–8, 3–12, 3–39, 3–50, 4–2, appendix B**
- Non–Army MTFs, administration of patients in**
 - Administration of patients treated at Federal MTFs other than the Uniformed Services and civilian facilities, 9–9
 - Army administrative units at Navy and Air Force MTFs, 9–3
 - Authorization, 9–5
 - Care in Federal MTFs other than those of the Uniformed Services, 9–4
 - Care in Navy and Air Force MTFs, 9–1
 - General policies, 9–2
 - Reimbursement to other Federal facilities, 9–7
 - Special consideration of USFHP beneficiaries, 9–8
 - Uniformed Services Family Health Plan locations, figure 9–1
 - Use of Federal medical treatment facilities for supplementation, 9–6
- Non–medical attendant travel, 2–6, 2–13, 5–18**
- Nonmilitary personnel**
 - Consent, 2–12
 - Cosmetic surgery, 2–19
 - Disposition types, 5–22
 - Elective cosmetic surgery, 2–19
 - Federal prisoners, 3–38, appendix B
 - Mentally ill in a foreign country, 5–23
 - Patient control, 4–1
 - Psychiatric disorders, 2–12, 2–15, 5–23
 - Travel reimbursement, 2–6
- Nursing home care, 4–5, 5–18**
- Observation bed status, 5–12**
- Optimum hospital benefit, 5–1, 5–6, glossary**
- Organ transplants donors and recipients, 3–63, appendix B**
- Orthopedic footwear, 3–2, 3–3, 3–12, 3–24, 7–24, appendix B**
- Outpatient care, table 2–1, 3–3, 3–20, 3–21, 3–23, 3–24, 3–29, 3–33, 3–48, 3–50, 3–62, 11–14, 11–15, 13–3, 13–6, 13–11, 14–1, appendix B**
- OWCP, 3–2, 3–3, 3–14, 3–16, 3–21, 3–24, 3–28, 3–33, 3–41, 3–43, 5–22, 7–5, figure 3–1, appendix B**
- Patient accountability and admission processes, 4–6**
- Patient control, 4–1**
- Patients in special circumstances**
 - Autopsy authority and consent, 6–5
 - Deceased persons, 6–4
 - General, 6–1
 - Hospitalization of special interest patients and enabling care policy, 6–3
 - Very seriously ill, seriously ill, SPECAT, 6–2
- Patient policies**
 - Abortions, 2–18
 - Admission of psychiatric patients, 2–15
 - Ancillary medical services, 2–16
 - Care beyond an MTFs capability, 2–14
 - Commercial transportation or travel and non–medical attendant travel, 2–6
 - Consent by a nonmilitary patient to medical care, 2–12
 - Cosmetic surgery, 2–19
 - Eligibility verification, 2–1
 - Family planning services, 2–17

- Hospitalization before the effective date of separation or retirement orders, 2–10
- Identification procedures, 2–2
- Maternity care for active duty members, 2–8
- Medical examinations for insurance purposes, 2–7
- NATO STANAG/ABCA QSTAG agreements, 2–5
- Patient transfers, 2–13
- Priorities, 2–3
- Primary care management, 2–4
- Remediable physical defects developed in the military service, 2–9
- Statements of prolonged hospitalization, 2–11
- Patient transfers, 2–13, 2–18, 3–2, 3–23, 3–24, 3–34, 3–38, 3–55, 4–5, 4–6, 4–7, 5–3, 5–4, 5–5, 5–9, 5–10, 5–11, 5–13, 5–14, 5–17, 5–18, 5–19, 5–20, 5–22, 5–23, 6–2, 6–3, 7–5, 7–14, 7–16, 8–3, 8–4, 9–3, 9–9, 13–6, 15–8**
- Patients' trust fund, 4–3, 4–5, 4–6, 11–19**
 - Administration, 12–2
 - Audit, 12–9
 - Forms, 12–7
 - Operating principles, 12–5
 - Procedures upon admission, 12–8
 - Purpose, 12–1
 - Responsibilities, 12–3
 - Safeguarding of funds and valuables, 12–6
 - Transfer of funds and valuables to successor custodians, 12–4
- Peace Corps, 3–24, 3–28, appendix B**
- Personal effects, 4–4, 4–5, 4–6**
- Physical disability processing, 5–2, 5–9, 8–4**
 - Appointing authority, 7–2
 - Composition, 7–3
 - Counseling members concerning medical board results, 7–17
 - Distribution of medical evaluation board proceedings, 7–13
 - Documentation for referral to a physical evaluation board, 7–10
 - Expeditious discharge, 7–11
 - General, 7–1
 - Interservice cooperation in medical evaluation board actions, 7–14
 - Medical board procedures for Medical Corps officers, 7–4
 - Medical evaluation board approving authority, 7–12
 - Medical evaluation board proceedings, 7–7
 - Options available to the Service reviewing authority, 7–16
 - Preparation of DA Form 3947, 7–9
 - Preparing MEB narrative summaries, 7–24
 - Processing actions related to the physical evaluation board, 7–19
 - Recording proceedings, 7–8
 - Records sent to a physical evaluation board, 7–23
 - Referral to the physical evaluation board liaison officer, 7–22
 - Referrals, 7–21
 - Sanity boards, 7–6
 - Transmittal of medical evaluation board proceedings by Service reviewing authority to Service physical evaluation boards, 7–18
 - Triservice medical evaluation board coordination, 7–15
 - Use of medical evaluation boards, 7–5
 - VA Physician's Guide for Disability Evaluation Examinations and the VASRD, 7–20
- Physical evaluation board, 3–2, 5–3, 5–5, 5–6, 5–9, 5–13, 5–17, 5–18, 5–19, 7–1, 7–5, 7–8, 7–9, 7–10, 7–11, 7–15, 7–18, 7–19, 7–21, 7–22, 7–23, 7–24**
- Power of attorney, 2–12, 5–14**
- Practical military training, 3–3, glossary**
- Preadoptive children and court appointed wards, 3–51, appendix B**
- Primary care manager, 2–4**

Priorities, 2-3, 2-14, 2-15, 2-18, 3-10, 3-11, 3-62, 7-1
 Prisoners, 3-31, 3-38, 3-57, 3-62, 4-6, 5-13, 5-14, 5-15, 7-13, 9-3, 10-1, 12-5, appendix B
 Prostheses, 3-2, 3-3, 3-12, 3-23, 3-24, 3-25, 3-41, 13-1, appendix B, glossary
 Psychiatric patients, 2-12, 2-15, 4-6, 5-13, 5-14, 5-15, 5-16, 5-18, 5-23, 6-2, 7-8, 7-10, 7-14, 7-24
 Public Health Service, 2-2, 3-25, 3-39, 3-41, appendix B
 Red Cross personnel, 3-42, appendix B
 References, appendix A
 Remediable physical defects developed in the military service, 2-9, 3-33
 Rosters, 4-6, 6-2, 6-3, 8-4, 8-14
 Routine care, 2-2, 3-23, 3-31, 5-12, 10-6, glossary
 Sanity board, 4-3, 5-16, 7-6
 Scouts, boy and girl, 3-46
 Seamen, 3-41, 10-1, appendix B
 Secret Service, 3-31, 3-37
 Secretarial designees, 2-2, 3-12, 3-29, 3-38, 3-50, 3-51, 3-52, 3-54, 3-62, 3-63, 3-64, appendix B
 Selective Service, 3-26, appendix B
 Sick call, 2-4, 5-12
 Social Security, table 2-1, 3-21, 3-34, appendix B
 Special interest patients and enabling care policy, 6-2, 6-3
 Specialized treatment services, 2-6, 2-19, 5-14
 Spectacles, 3-2, 3-3, 3-12, 3-15, 3-23, 3-24, appendix B
 Status of Forces Agreement (SOFA), 2-12, table 2-1, 3-18
 Sterilization, surgical, 2-12, 2-17, 2-18
 Student, civilian, 3-43
 Subsistence, 2-19, 3-2, 3-14, 3-15, 3-21, 3-29, 3-37, 3-42, 3-43, 3-45, 3-46, 3-47, 3-50, 5-7, 9-2, 13-6, 14-8, appendix B, glossary
 Subsisting out status, 4-1, 5-7, 8-4, glossary
 Supplemental care, table 2-1, table 2-2, table 2-3, 2-14, 10-1, 13-2, 13-6, glossary
 Temporary disability retired list, 2-6, 3-10, 5-5, 5-6, 5-8, 5-18, 7-5, 7-21, 7-22, 9-4, 10-1
 Third Party Collection Program, 13-1, 13-2, 13-5, 13-7
 Authorization to release medical information in support of the Third Party Collection Program, 14-7
 Claims activities, 14-8
 Collection activities, 14-9
 Disposition of claims files, 14-12
 Health plans not subject to, 14-2
 Identification of beneficiaries who have other insurance, 14-5
 Mandatory compliance by health insurance carriers, 14-6
 Medical services billed, 14-3
 Medical services not billed, 14-4
 Minimum internal controls, 14-10
 Policy, 14-1
 Reports, 14-11
 TRICARE, 2-3, 2-4, 2-8, 2-13, 2-14, 2-18, table 2-1, table 2-2, table 2-3, 3-2, 3-11, 3-13, 3-51, 3-52, 10-1, 10-5, 10-6, 13-1, 13-8, 13-9, 13-10, 14-2, 14-8, glossary
 Tripler Army Medical Center, 3-17, 3-28, 3-35, 3-36, 3-59, appendix B
 Uniformed Services Family Health Plan, 9-8, figure 9-1
 Uniformed Services University of Health Sciences, 3-64, appendix B
 Unremarried former spouse, 3-66, appendix B
 U.S. Customs agents, 3-31, appendix B
 U.S. Soldiers' and Airmen's Home, 3-29, appendix B
 VA Physician's Guide for Disability Evaluation Examinations, 7-3, 7-20
 Very seriously ill, seriously ill, SPECAT, 4-7, 6-1, 6-2, 6-3, 9-9
 Veterans Affairs, Department of, 2-13, 3-23, 3-61, 4-1, 4-5, 5-3, 5-11, 5-13, 5-17, 5-18, 5-19, 7-5, 7-10, 7-20, 8-4, 9-4
 Volunteer Programs in Service to America, 3-33, appendix B
 Volunteer subjects in research projects, 3-56

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